Supreme Court, U.S.
FILED
SEP 6 - 2006
OFFICE OF THE CLERK

No. 06-324

In the
Supreme Court of the United States

BLUE CROSS & BLUE SHIELD OF MICHIGAN,
Petitioner,

v.

MICHAEL A. GENORD, M.D.; JOHN R. SANBORN, M.D.; PAULA M. FISHBAUGH, M.D.; ANDREA L. SCHILLER, M.D.; MARK D. DYKOWSKI, M.D.; JOHN E. ECKELE, M.D.; BETTY S. CHU, M.D.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

In *United States Department of Treasury v. Fabe*, this Court confirmed that Congress' intent in enacting § 2(b) of the McCarran-Ferguson Act was to establish the states' "broad regulatory authority over the business of insurance." Did the Sixth Circuit depart from this Court's decision in *Fabe* when it held that Michigan's law mandating and regulating reimbursement arrangements between Petitioner Blue Cross & Blue Shield of Michigan and medical providers for the express statutory purpose of ensuring policyholders reasonable access to quality health care at a reasonable cost was not protected from preemption under the McCarran-Ferguson Act as a state law "enacted . . . for the purpose of regulating the business of insurance"?

RULE 29.6 STATEMENT

Petitioner has no parent corporation, and no publicly held company owns 10% or more of its stock.

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PETITION FOR WRIT OF CERTIORARI

Petitioner Blue Cross & Blue Shield of Michigan ("BCBSM") respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit.

OPINIONS BELOW

The Sixth Circuit's published opinion (App. at 3a-16a) is reported at 440 F.3d 802. The district court's unpublished opinion is attached at App. at 19a-38a.

JURISDICTION

The judgment of the United States Court of Appeals for the Sixth Circuit was entered on March 14, 2006. App. at 17a-18a. The court's denial of BCBSM's petition for rehearing en banc was entered on June 9, 2006. App. at 1a-2a. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1011, states:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after

> June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1012(b).

Various provisions of Michigan's statutory regulation of health insurance, including the Nonprofit Health Care Corporation Reform Act, Mich. Comp. Laws § 550.1101 *et seq.*, and related administrative rules, are also involved in this case:

Mich. Comp. Laws § 550.53
Mich. Comp. Laws § 550.1102(1)
Mich. Comp. Laws § 550.1401(7)
Mich. Comp. Laws § 550.1404
Mich. Comp. Laws § 550.1502
Mich. Comp. Laws § 550.1502a
Mich. Comp. Laws § 550.1504(1)
Mich. Admin. Code R. 550.101 *et seq.*

The pertinent text of these provisions is set out in the Appendix at 123a-143a.

INTRODUCTION

This case involves the Sixth Circuit's failure to follow the controlling standard established by this Court in *United States Department of Treasury v. Fabe*, 508 U.S. 491 (1993), for

determining whether a state law was "enacted . . .for the purpose of regulating the business of insurance" within the meaning of the first clause of § 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1011, which prohibits application of a general federal law that would "invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance." *Fabe* explained that the purpose of this provision was to "further Congress' primary objective of granting the States broad regulatory authority over the business of insurance." *Fabe*, 508 U.S. at 505. *Fabe* further emphasized that the first clause of § 2(b) must be distinguished from the second clause, which narrowly exempts only certain *activities* from antitrust scrutiny.

The Sixth Circuit fundamentally departed from this Court's decision in *Fabe* when it held that Michigan's comprehensive statutory health insurance scheme regulating, among other things, agreements between Petitioner Blue Cross Blue Shield of Michigan ("BCBSM") and medical providers, and reimbursement issues arising thereunder, was not "enacted . . . for the purpose of regulating the business of insurance," and that the McCarran-Ferguson Act did not prohibit Respondents' claims against BCBSM under the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. § 1964(c), for BCBSM's allegedly improper denials of Respondents' claims for reimbursement and delays in processing those claims. As discussed below, the Sixth Circuit's decision creates a conflict with the Fourth Circuit as to whether state laws regulating provider reimbursement issues are protected from federal preemption under the McCarran-Ferguson Act, and furthers an existing conflict among the circuits as to the analysis required under *Fabe*.

In recognition of Congress' goal of protecting state regulation of insurance from interference by federal laws not

dealing with the regulation of insurance, *Fabe* adopted an expansive definition of the statutory phrase "enacted . . . for the purpose of regulating the business of insurance":

> The broad category of laws enacted "for the purpose of regulating the business of insurance" consists of laws that possess the "end, intention, or aim" of adjusting, managing, or controlling the business of insurance.

Fabe, 508 U.S. at 505 (citation omitted). The Court further observed that "'[s]tatutes aimed at protecting or regulating this relationship [between insurer and insured], *directly or indirectly*, are laws regulating the "business of insurance,"' within the meaning of the phrase." *Fabe*, 508 U.S. at 501 (citation omitted; emphasis added).

In determining that the statutory provisions regulating BCBSM's reimbursement arrangements with medical providers were not "enacted . . . for the purpose of regulating the business of insurance," the Sixth Circuit did not apply the standard established by *Fabe* because it failed to broadly examine the purposes of Michigan's statutory scheme governing health insurance, and its regulation of provider reimbursement issues, to determine whether it is "'aimed at protecting or regulating [the] relationship [between insurer and insured], directly or indirectly.'" *Fabe*, 508 U.S. at 501. Instead, the Sixth Circuit improperly applied a narrow analysis that focused on whether the provider reimbursement arrangements themselves, in isolation, met the criteria set forth in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982), for determining whether certain *activities* are exempt from federal antitrust laws under the *second* clause of § 2(b). App. at 10a-15a.

In *Fabe*, the Court explained that an analysis such as the Sixth Circuit's is improper in cases arising, as here, under the first clause of § 2(b). According to the Court, the first and second clauses have to be distinguished because they serve different purposes:

> The first clause commits laws "enacted . . . for the purpose of regulating the business of insurance" to the States, while the second clause exempts only "the business of insurance" itself from the antitrust laws. To equate laws "enacted . . . for the purpose of regulating the business of insurance" with the "business of insurance" itself . . . would be to read words out of the statute.

Fabe, 508 U.S. at 504. As *Fabe* emphasized, the objective of the first clause of § 2(b) – protecting state regulation of the insurance industry – can only be fulfilled by viewing the purpose of the state law at issue broadly to determine if it possesses the "'end, intention, or aim,' of adjusting, managing, or controlling the business of insurance," *Fabe*, 508 U.S. at 505, and is "'aimed at protecting or regulating [the] relationship [between insurer and insured], *directly or indirectly*.'" *Id.* at 501 (emphasis added).

In this case, the Sixth Circuit did not follow the mandated distinction between the first and second clauses of § 2(b), and instead applied a narrow, antitrust-based analysis that has no place in determining whether a state insurance law should be protected from preemption. Although, as discussed more fully below, BCBSM's provider reimbursement arrangements nonetheless also satisfy the *Pireno* antitrust criteria, the Sixth Circuit's error is far more fundamental than a misapplication of those criteria. The Sixth Circuit never should have applied

the *Pireno* criteria in the first place. This is because, contrary to *Fabe*, the Sixth Circuit focused on the reimbursement arrangements themselves as opposed to *the purpose of Michigan's comprehensive statutory regulation of the insurer-provider relationship*. Applying the controlling standard set out in *Fabe*, those provisions are "'aimed at protecting or regulating'" the relationship between BCBSM and its policyholders.

The Sixth Circuit's decision is also in direct conflict with the Fourth Circuit's decision in *American Chiropractic Association v. Trigon Healthcare, Inc.*, 367 F.3d 212 (4th Cir. 2004). Properly applying *Fabe*, and contrary to the Sixth Circuit's decision in this case, the Fourth Circuit stated that it had "little difficulty" finding a Virginia statute mandating reimbursement of all providers of covered medical services to have been "enacted . . . for the purpose of regulating the business of insurance" within the meaning of the first clause of § 2(b).

The Court should be concerned about this conflict because the issue of whether laws regulating reimbursement issues between insurers and medical providers fall within the protective ambit of the McCarran-Ferguson Act is one of critical importance to the health insurance industry. Allowing medical providers to pursue RICO claims against health insurers over reimbursement disputes that are already comprehensively regulated under state law seriously undermines the ability of the states to regulate those issues for the protection of policyholders.

The Court should also be concerned about the conflict between *Trigon* and the Sixth Circuit's decision in this case because it reflects an existing, and widespread conflict among the circuits as to whether application of the first clause of

§ 2(b) requires, under *Fabe*, a broad analysis focusing on whether a state law at issue is "'aimed at protecting or regulating [the] relationship [between insurer and insured], directly or indirectly,'" *Fabe*, 508 U.S. at 505, instead of whether a specific *activity* being regulated meets the *Pireno* antitrust criteria. As the Third Circuit observed in *Sabo v. Metropolitan Life Ins. Co.*, 137 F.3d 185, 189 n. 2 (3rd Cir. 1998): "[F]ederal courts have seemingly disagreed as to the proper analytic inquiry into McCarran-Ferguson Act preclusion."

This Court should take jurisdiction of this case to affirm the central holding in *Fabe* and to clarify the most important principle in connection with the McCarran-Ferguson Act – that states should be the primary source of regulation of the business of insurance. Such clarification will not only correct the Sixth Circuit's manifest error, but it will also eliminate uncertainty and conflict among other federal courts that have reached different conclusions about how to apply the first clause of § 2(b) under *Fabe*.

STATEMENT OF THE CASE

A. Factual Background

Respondents are Michigan doctors (sometimes referred to as "providers") who claim that they provided gynecological services to BCBSM's policyholders and that their claims for reimbursement were improperly denied, underpaid, or delayed as a result of a change in the billing codes utilized by BCBSM. Respondents allege that BCBSM's conduct violated RICO. App. at 107a-122a. Respondents' RICO claims are the sole basis for federal jurisdiction in this case. Respondents also alleged state law claims for breach of contract, unjust enrichment, and violation of the Michigan

Uniform Trade Practices Act, Mich. Comp. Laws § 500.2006.

B. Proceedings in the District Court

BCBSM filed a motion to dismiss under Fed. R. Civ. P. 12(b)(1) and (6) on the primary ground that Respondents' RICO claims are barred by the McCarran-Ferguson Act, and that the district court therefore lacked subject matter jurisdiction over the case. BCBSM argued that its reimbursement arrangements with contracting medical providers are governed by Michigan law, which, as discussed *infra*, mandates the use of such arrangements and establishes a detailed regulatory framework governing reimbursement between BCBSM and medical providers. BCBSM further argued that allowing Respondents' RICO claims to proceed would "invalidate, impair or supersede" Michigan's comprehensive regulation of BCBSM's activities.

The district court initially took the matter under advisement and requested supplemental briefing. App. at 78a-79a. The district court subsequently denied BCBSM's request that the RICO claims be dismissed. App. at 19a-38a. The court concluded, in relevant part, that BCBSM's reimbursement arrangements with medical providers are not part of the "business of insurance because the contracts are not between an insurance company and its policyholders." *Id.* at 32a. In light of that determination, the district court did not address whether application of RICO would "invalidate, impair, or supersede" Michigan's regulation of provider reimbursement issues.

C. Proceedings in the Sixth Circuit

After the district court certified the McCarran-Ferguson Act issue for interlocutory appeal (App. at 85a-86a), the Sixth Circuit granted BCBSM's petition for permission to appeal and agreed to decide the issue. (App. at 82a-84a).

In a published opinion, the Sixth Court affirmed the district court's decision. App. at 3a-16a. The Sixth Circuit recognized that BCBSM is "regulated extensively" under Michigan law, and that Michigan requires it to "enter into reimbursement agreements with various medical providers" in order to "'assure subscribers reasonable access to, and reasonable cost and quality of, health care services.'" *Id.* at 4a-5a (*quoting* Mich. Comp. Laws § 550.1504(1)).

Contrary to *Fabe*, however, the Sixth Circuit did not examine the purpose of Michigan's regulation of provider reimbursement and whether that regulation is for the protection of policyholders. The Sixth Circuit instead analyzed whether the reimbursement arrangements themselves met the narrow antitrust exemption contained in the second clause of § 2(b), using criteria developed in the *antitrust* context for determining what *activities* constitute the "business of insurance":

> (1) "whether the practice has the effect of transferring or spreading a policyholder's risk," (2) "whether the practice is an integral part of the policy relationship between the insurer and the insured," and (3) "whether the practice is limited to entities within the insurance industry."

App. at 9a-10a, *quoting Pireno*, 458 U.S. at 129.

The Sixth Circuit first found that BCBSM's provider reimbursement arrangements are not part of a legislative scheme to "transfer or spread policyholder risk" since they relate solely to how BCBSM "goes about making health care services available to its policyholders." App. at 11a. The Sixth Circuit thus reasoned that these arrangements are the same as the "ancillary" pharmacy discount agreements that this Court held not to be exempt from antitrust scrutiny under the *Pireno* criteria in *Group Life & Health Insurance Co. v. Royal Drug*, 440 U.S. 205 (1979). *Id.* at 11a-12a.

Turning to the second *Pireno* criterion, the Sixth Circuit found that BCBSM's provider reimbursement arrangements do not further the interests of its policyholders, who the Sixth Circuit found to be "unconcerned with the reimbursement arrangements between Blue Cross and doctors so long as they receive medical treatment as contemplated by their agreement with Blue Cross." App. at 14a. According to the Sixth Circuit, the reimbursement arrangements are therefore not an integral part of BCBSM's relationship with its policyholders. *Id.*

As to the third *Pireno* criterion, the Sixth Circuit concluded that "because the doctors are not entities within the insurance industry," Michigan's statutory provisions governing their reimbursement "do not 'lie at the center . . . of legislative concern' of the McCarran-Ferguson Act." *Id.* at 15a, *quoting Pireno*, 458 U.S. at 133.

REASONS FOR GRANTING THE PETITION

I. THE SIXTH CIRCUIT'S DECISION CONFLICTS WITH THIS COURT'S DECISION IN *FABE*

In *Fabe*, 508 U.S. at 505, this Court emphasized the important distinction between the first and second clauses of § 2(b):

> [T]he first clause of § 2(b) was intended to further Congress' primary objective of granting the States broad regulatory authority over the business of insurance. The second clause accomplishes Congress' secondary goal, which was to carve out only a narrow exemption for "the business of insurance" from the federal antitrust laws.

Addressing the first clause of § 2(b) and its broad goal of protecting state regulation of the "business of insurance," *Fabe* explained that "'[s]tatutes aimed at protecting or regulating th[e] relationship [between insurer and insured], directly or indirectly, are laws regulating the 'business of insurance.'" *Id.* at 501, *citing SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969). According to the Court, this "broad category of laws . . . consists of laws that possess the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance," *id.* at 505, and it "necessarily encompasses more than just the 'business of insurance.'" *Id.*

The distinction drawn in *Fabe* between the first and second clauses of § 2(b) is entirely consistent with both the text and the underlying purpose of those provisions. As *Fabe* explained, the first clause is designed to ensure that states have the primary authority in regulating the business of

insurance. Thus, in determining whether a state law should be protected from preemption, it is necessary to examine the "purpose" of the state law and whether it is intended to regulate "the business of insurance" by protecting the interests of policyholders. It is only by broadly examining the state law's purpose that effect can be given to the first clause's goal of protecting state regulation of the business of insurance. On the other hand, the second clause of § 2(b) creates a narrow exception to the antitrust laws only for certain *activities* in which insurance companies may engage. Because the antitrust laws are concerned with whether certain specific *conduct* should or should not be permitted, it is logical that only a narrow, activity-specific exemption be embodied in the second clause of § 2(b).

By applying the *Pireno* antitrust criteria as controlling the determination of whether a state law was enacted "for the purpose of regulating the business of insurance," the Sixth Circuit disregarded *Fabe* by taking a restrictive view of the first clause of § 2(b) that nullifies Congress' objective of preserving the states' regulatory authority over insurance. *Fabe*, 508 U.S. at 505. Contrary to the Sixth Circuit's analysis, *Fabe* expressly distinguished *Pireno* and *Royal Drug* because those cases involved only whether particular *activities* were exempt from federal antitrust laws under the *second* clause of § 2(b). *Fabe* explained that the first clause of § 2(b) is "not so narrowly circumscribed":

> Both *Royal Drug* and *Pireno* . . . involved the scope of the antitrust immunity located in the *second* clause of § 2(b). We deal here with the *first* clause, which is not so narrowly circumscribed. The language of § 2(b) is unambiguous: The first clause commits laws "enacted . . . for the purpose of regulating the

> business of insurance" to the States, while the second clause exempts only "the business of insurance" itself from the antitrust laws. To equate laws "enacted ... for the purpose of regulating the business of insurance" with the "business of insurance" itself, as petitioner urges us to do, would be to read words out of the statute. This we refuse to do.

Id. at 504. Here, the Sixth Circuit erred by applying the narrow *Pireno* antitrust criteria developed under the second clause of § 2(b), which deals with whether particular *activity* is exempt from the antitrust laws, when the pertinent inquiry here is whether, under the first clause of § 2(b), Michigan's comprehensive regulation of BCBSM's provider reimbursement arrangements is "'aimed at protecting or regulating th[e] relationship [between insurer and insured], directly or indirectly." *Id.* at 501.

Under *Fabe*, it is apparent that the regulation of provider reimbursement under Michigan law is "aimed at protecting or regulating" the relationship between BCBSM and its policyholders. Indeed, the express purpose of that regulation is to *assure BCBSM's subscribers access to affordable and quality health care services*:

> (1) A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement *to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals*:

> (a) There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.
>
> (b) Providers will meet and abide by reasonable standards of health care quality.
>
> (c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

Mich. Comp. Laws § 550.1504(1) (emphasis added); *see also* Mich. Comp. Laws § 550.1102(1) ("It is the purpose and intent of this act, and the policy of the legislature, to . . . assure . . . reasonable access to, and reasonable cost and quality of, health care services . . . ."); Mich. Comp. Laws § 550.1502a and Mich. Comp. Laws § 550.53(1) (mandating agreements which "control health care costs, assure appropriate utilization of health care services, and maintain quality of health care.")

In order to accomplish these goals, the Michigan Legislature crafted its statutory scheme of health insurance so that provider reimbursement issues were comprehensively regulated for the benefit of policyholders. For example, Michigan law details requirements for all "contracts for reimbursement with professional health care providers." Mich. Comp. Laws § 550.1502(1). It also requires that medical providers accept payment at regulated rates in full for services covered under BCBSM's certificates. Mich. Comp. Laws § 550.1502(1)(a). BCBSM is even prohibited from

directly reimbursing providers who have not entered into a regulated reimbursement contract with BCBSM. Mich. Comp. Laws § 550.1401(7).

Finally, Michigan law provides a specific procedure for bringing reimbursement disputes before the Insurance Commissioner. Mich. Comp. Laws § 550.1404. *See also* Mich. Admin. Code R. 550.101 *et seq.* (setting forth the administrative procedure by which a "person who believes that a health care corporation has wrongfully refused his or her claim" can seek review before the Commissioner; a "claim" includes a "request for payment by a provider under his or her agreement with a health care corporation").

In light of these provisions, the Sixth Circuit's conclusion that policyholders are "largely unconcerned" about Michigan's regulation of provider reimbursement (App. at 15a; *see also* App. at 14a) cannot withstand serious scrutiny. To the contrary, the regulation of provider reimbursement arrangements is, under *Fabe*, "aimed at protecting or regulating" the relationship between BCBSM and its policyholders because it assures policyholders access to health care services under a statutory scheme controlling their costs of such coverage. BCBSM's provider reimbursement arrangements affect not only the premiums paid by policyholders, but the number of doctors and hospitals available to them and the quality of care provided. Michigan's statutorily-mandated provider reimbursement arrangements do this by establishing a comprehensive network of providers who have agreed to provide medical services to BCBSM's policyholders under regulated contract provisions.

In concluding that Michigan's statutory regulation of BCBSM's reimbursement arrangements with medical providers does not affect policyholders, the Sixth Circuit

applied a test under the McCarran-Ferguson Act that conflicts with this Court's decision in *Fabe*. Even though the Sixth Circuit acknowledged that this case arises under the first clause of § 2(b) (App. at 8a-9a), thus requiring a broad focus on Michigan's legislative purposes in mandating and regulating provider reimbursement arrangements, the Sixth Circuit nevertheless analyzed the reimbursement arrangements narrowly to determine whether they met the *Pireno* criteria developed in cases addressing antitrust immunity for certain *conduct* under the second clause of § 2(b). Although, as discussed below, the provider reimbursement arrangements *do* meet the *Pireno* antitrust criteria, the Sixth Circuit fundamentally erred in applying them at all. Instead, the Sixth Circuit should have applied the broad analysis mandated by *Fabe*, which is whether Michigan's statutory scheme of regulation of those arrangements is "'aimed at protecting or regulating th[e] relationship [between insurer and insured].'" *Fabe*, 508 U.S. at 501.

As the Seventh Circuit observed in *Autry v. Northwest Premium Services, Inc.*, 144 F.3d 1037, 1042 (7th Cir. 1998):

> The Supreme Court [in *Fabe*] did not simply look to the activity being regulated to determine whether it qualified as the "business of insurance." Instead, it dissected the statute and looked to an ultimate effect of the statute: increased probability of the enforcement of the insurance contract. Thus, a statute that regulates bankruptcy proceedings may still be a statute "enacted . . . for the purpose of regulating the business of insurance" even though bankruptcy proceedings themselves are not the "business of insurance."

The problem with focusing solely on the *activity* at issue without regard to the *purpose* of the state law that regulates the activity is that, contrary to *Fabe:*

> [I]t casts too small a net to capture all of the statutes that were "enacted . . . for the purpose of regulating the business of insurance." There will be cases where the regulated activity does not constitute the "business of insurance" as that term is defined in *Pireno*, yet the statute that regulates the activity may have been enacted "for the purpose of regulating the business of insurance."

Id.

The Sixth Circuit in this case made the precise error identified in *Autry* – it focused on BCBSM's provider reimbursement arrangements (i.e., the *activity*) and whether they themselves constitute the "business of insurance," without any regard for the *purpose* of the state's regulation of those arrangements – to assure reasonable access to quality health care and to control health care costs.

The Sixth Circuit's failure in this regard is especially remarkable because the Sixth Circuit has previously demonstrated its understanding of the distinction drawn in *Fabe* between the first and second clauses of § 2(b). In *International Insurance Co. v. Duryee*, 96 F.3d 837 (6th Cir. 1996), the Sixth Circuit explained that *Fabe* distinguished *Royal Drug* and *Pireno* because those cases involved "a related but distinct phrase of the McCarran-Ferguson Act," i.e., its antitrust immunity provision:

> While confirming that *Pireno* provides the three-factor test for determining whether certain practices are part of the "business of insurance," the *Fabe* Court found that the "broad category of laws enacted 'for the purpose of regulating the business of insurance' . . . necessarily encompasses more than just the 'business of insurance.'"

Id. at 839. In *AmSouth Bank v. Dale*, 386 F.3d 763, 781 (6th Cir. 2004), the Sixth Circuit similarly observed that, under *Fabe*, "McCarran-Ferguson reverse preemption depends upon the policies that undergird state law."

Rather than follow *Duryee* and *AmSouth*, the Sixth Circuit inexplicably disregarded them and instead cited *Owensboro National Bank v. Stephens*, 44 F.3d 388 (6th Cir. 1994), which was decided two years before *Duryee* and ten years before *AmSouth*. In *Owensboro*, the Sixth Circuit held that "to have been 'enacted . . . for the purpose of regulating the business of insurance,' [the state law] must possess the aim of regulating activities that meet the *Pireno* criteria." *Id.* at 392. Although *Owensboro* found such an analysis to be consistent with *Fabe*, it actually disregards *Fabe*'s instruction that the first clause of § 2(b) covers a "broad category of laws . . . [that] necessarily encompasses more than just the 'business of insurance.'" *Fabe*, 508 U.S. at 505. The dissent in *Owensboro* properly recognized that fact in arguing that the *Pireno* criteria were inapplicable and that "the Supreme Court's recent opinion in [*Fabe*] sets the controlling criteria in this case." *Id.* at 394 (Batchelder, J. dissenting).

The Sixth Circuit's decision here to apply the outmoded, *Pireno*-based analysis from *Owensboro* instead of the broader analysis required under *Fabe*, which the Sixth Circuit did

follow in *Duryee* and *AmSouth* (neither of which even mentioned *Owensboro*), is beyond troubling and further demonstrates the need for clarification from this Court. *See also Kenty v. Bank One, Columbus, N.A.*, 92 F.3d 384 (6th Cir. 1996) (relying on the *Pireno* criteria even though the first clause of § 2(b) was at issue).

Contrary to both *Fabe* and its own prior decisions in *Duryee* and *AmSouth*, the Sixth Circuit in this case failed to heed *Fabe*'s mandate that the narrow focus on the activity being regulated under the *Pireno* criteria *is only appropriate when that activity is claimed to be in violation of the antitrust laws*. *Fabe*, 508 U.S. at 505. In disregarding *Fabe*'s holding that a broader analysis applies when the first clause of § 2(b) is at issue, the Sixth Circuit has sanctioned a wholesale interference with the ability of states to oversee the framework within which health insurers operate. The Court should grant certiorari in order to correct the Sixth Circuit's error and to clarify the proper analysis under *Fabe*.

II. THE SIXTH CIRCUIT'S DECISION CONFLICTS WITH A DECISION FROM THE FOURTH CIRCUIT ADDRESSING THE SAME IMPORTANT FEDERAL QUESTION INVOLVED IN THIS CASE

The Sixth Circuit's decision in this case is also in direct conflict with the Fourth Circuit's decision in *American Chiropractic Association v. Trigon Healthcare, Inc.*, 367 F.3d 212, 230-231 (4th Cir. 2004). *Trigon* involved a claim by chiropractors that a health insurer, in violation of RICO, had used its "reimbursement policies and treatment guidelines to limit severely the flow of insurance dollars to chiropractors and steer those monies toward medical doctors." 367 F.3d at 217-218. Properly recognizing that, under *Fabe*, the first clause of § 2(b) broadly encompasses all "'laws that possess

the "end, intention, or aim" of adjusting, managing, or controlling the business of insurance,'" the Fourth Circuit stated that it had "little difficulty" concluding that the Virginia laws at issue were "enacted for the purpose of regulating the business of insurance":

> [T]he McCarran-Ferguson Act encompasses "laws that possess the 'end, intention, or aim' of adjusting, managing, or controlling the business of insurance." Applying these standards, Title 38.2 of the Code of Virginia, specifically §§ 38.2-200, 38.2-221 and 38.2-3408 at issue here, is a set of laws enacted for the purpose of regulating the business of insurance. Title 38.2 is limited to insurance companies and creates a comprehensive network of statutory provisions aimed at controlling and managing the business of insurance. For instance, § 38.2-3408, by requiring insurers to provide reimbursement for all providers of covered services, helps to manage the relationship between the policyholder and the insurance company by ensuring that if a particular service is covered by an insurance company, the policyholder can seek treatment from any provider able to perform that service.

Id. at 231.

The Sixth Circuit's decision here is in direct conflict with the Fourth Circuit's decision in *Trigon*, which the Sixth Circuit did not even acknowledge, much less address, in its opinion. The conflict on this issue also extends to the district court level. *See In re Managed Care Litigation*, 298 F.

Supp.2d 1259, 1283-1285 (S.D. Fla. 2003) (finding provider reimbursement agreements to "fall[] outside the 'business of insurance'"); *Everson v. Blue Cross & Blue Shield of Ohio*, 898 F. Supp. 532, 543 (N.D. Ohio 1994) (holding that negotiations of discounts with medical providers constituted the "business of insurance" regulated by Ohio law).

This conflict is significant because the use of reimbursement arrangements such as those regulated under Michigan law is widespread in an effort to control escalating health care costs and to regulate the provision of health care services to insureds. States, health insurers, and insureds all have a direct, continuing and abiding interest in knowing that state insurance laws and regulations will continue to be respected. By granting certiorari and resolving this conflict, the Court can ensure a uniform, national approach to determining whether state laws regulating the relationship between health insurers and medical providers are laws "'aimed at protecting or regulating' [the] relationship [between insurer and insured], directly or indirectly.'" *Fabe*, 508 U.S. at 501.

III. THERE IS A CONFLICT AMONG THE CIRCUITS AS TO THE ANALYSIS REQUIRED UNDER *FABE*

The conflict between the Sixth and Fourth Circuits is also significant because it exemplifies the broader conflict that exists among the circuits as to the analysis required under the first clause of § 2(b). Indeed, ever since *Fabe*, lower federal courts have struggled to determine the analysis required under *Fabe* for such cases. As the district court observed in *Ambrose v Blue Cross & Blue Shield of Virginia*, 891 F. Supp. 1153, 1161 n. 5 (E.D. Va. 1995), *aff'd* 95 F.3d 41 (4th Cir. 1996), "[s]ome post-*Fabe* decisions have continued to

analyze whether the *practice* that is the subject of the federal law constitutes 'the business of insurance'" even though *Fabe* adopted a "broader analysis where the first clause of Section 2(b) is at issue." *See also Sabo v. Metropolitan Life Ins. Co.*, 137 F.3d 185, 189 n. 2 (3rd Cir. 1998) (noting that "federal courts have seemingly disagreed as to the proper analytic inquiry into McCarran-Ferguson Act preclusion.").

The First, Fourth, Seventh, Eighth, Tenth, and Federal circuits all apply an analysis in cases arising under the first clause of § 2(b) that, as directed by *Fabe*, properly focuses on the *purpose* of the state law at issue as opposed to a narrow application of the *Pireno* antitrust criteria to the *practice* being regulated. In *Doe v. Norwest Bank Minnesota, N.A.*, 107 F.3d 1297 (8th Cir. 1997), for example, the Eighth Circuit observed that "*Fabe* recognizes that the [*Pireno* analysis] for determining whether a particular practice constitutes the business of insurance is relevant only in cases involving a conflict between state law and federal antitrust law." *Id.* at 1305 n. 8. As the Seventh Circuit explained in *Autry*, the distinction between the analyses required under the first and second clauses of § 2(b) "is far from inconsequential," as demonstrated by an analysis of the statute at issue in *Fabe*:

> Take, for example, the statute at issue in *Fabe*. The state statute at issue regulated creditor priority in a bankruptcy dissolution and gave policyholders a higher preference than they received under the federal statute. If we asked only whether the activity in question, bankruptcy dissolution, was the "business of insurance" as defined in *Pireno*, the answer would be "no." If the activity in question is not the "business of insurance," it would follow . . . that the statute enacted to regulate

> it cannot be a statute "enacted ... for the purpose of regulating the business of insurance." Yet, as the Supreme Court noted, the preferencing of policyholders "serves to ensure that, if possible, policyholders ultimately will receive payment on their claims." [*Fabe*, 508 U.S. at 506]. "Because the [state] statute is 'aimed at protecting or regulating' the performance of an insurance contract ... it follows that it is a law 'enacted for the purpose of regulating the business of insurance' within the meaning of the first clause of § 2(b)." [*Id.* at 505] (citation omitted).

Autry, 144 F.3d at 1042. The First, Fourth, Tenth, and Federal Circuits have, relying on *Fabe*, likewise given broad effect to the first clause of § 2(b) and the purpose of the state law at issue without regard to whether the conduct regulated by the state law is itself within the "business of insurance" under the *Pireno* antitrust criteria. *See Ruthardt v. United States,* 303 F.3d 375, 380-384 (1st Cir. 2002) (applying *Fabe* broadly to provisions of Massachusetts statute governing priority of claims against insolvent insurers); *Trigon*, 367 F.3d at 230-231 (finding Virginia insurance laws requiring reimbursement to all providers willing to provide covered services were enacted "to manage the relationship between the policyholder and the insurance company"); *Davister Corp. v. United Republic Life Ins. Co.*, 152 F.3d 1277, 1279-1282 (10th Cir. 1998) (finding Utah statute consolidating and staying all proceedings against an insolvent insurance company to have been enacted "to protect policyholders" within the meaning of the first clause of § 2(b)); *Greene v. United States*, 440 F.3d 1304, 1309-1317 (Fed. Cir. 2006) (observing that *Fabe* "rejected the notion that 'regulation of

insurance' was restricted to the *'business* of insurance,'" making clear that the touchstone of regulation is instead *the extent to which it protects policyholders*") (citation omitted) (emphasis in original).

Notwithstanding *Fabe*'s instruction that the focus under the first clause of § 2(b) is on the purpose of the state law as opposed to the specific activity being regulated, the Second, Ninth and Eleventh – and apparently the Sixth – circuits continue to apply the *Pireno* antitrust factors narrowly to determine whether the *practice* at issue falls within the "business of insurance" even in cases that do not involve the McCarran-Ferguson Act's antitrust exemption. *See, e.g., Stephens v. American International Co.*, 66 F.3d 41, 44 (2nd Cir. 1995); *Merchants Home Delivery Service, Inc. v. Frank B. Hall & Co., Inc.*, 50 F.3d 1486, 1490 (9th Cir. 1995); *Blackfeet National Bank v. Nelson*, 171 F.3d 1237, 1246 (11th Cir. 1999).

As demonstrated by these divergent decisions, there has been substantial confusion and conflict among the circuits in the post-*Fabe* era as to *Fabe*'s instruction that the analysis under the first clause of § 2(b) should broadly focus on the purpose of the state law and whether it is "'aimed at protecting or regulating [the] relationship [between insurer and insured], directly or indirectly.'" *Fabe*, 508 U.S. at 501. By issuing a writ of certiorari in this case and clarifying that the narrow *Pireno* criteria apply *only* in antitrust cases under the second clause of § 2(b), this Court can provide much-needed guidance to the lower courts.

IV. EVEN UNDER THE NARROW ANALYSIS EMPLOYED IN *PIRENO* AND *ROYAL DRUG*, THE SIXTH CIRCUIT ERRED IN FINDING THAT MICHIGAN'S REGULATION OF PROVIDER REIMBURSEMENT ARRANGEMENTS DOES NOT BENEFIT POLICYHOLDERS

In further support of its decision in this case, the Sixth Circuit relied heavily on this Court's decision in *Royal Drug*, which, like *Pireno*, involved a narrow application of § 2(b)'s antitrust exemption provision. Not only is *Royal Drug* inapposite for that reason, but even under the analysis employed in *Royal Drug*, there can be no dispute that BCBSM's statutorily-mandated and heavily-regulated reimbursement arrangements with medical providers satisfy the *Pireno* criteria.

In *Royal Drug*, this Court was faced with whether pharmacy discount agreements between the defendant insurer and participating pharmacies were exempt from federal antitrust laws pursuant to the second clause of § 2(b). *Royal Drug* explained the operation of those agreements as follows:

> If the pharmacy selected by the insured has entered into a "Pharmacy Agreement" with Blue Shield, and is therefore a participating pharmacy, the insured is required to pay only $2 for every prescription drug. The remainder of the cost is paid directly by Blue Shield to the participating pharmacy. If, on the other hand, the insured selects a pharmacy which has not entered into a Pharmacy Agreement, and is therefore a non-participating pharmacy, he is required to pay

> the full price charged by the pharmacy. The insured may then obtain reimbursement from Blue Shield for 75% of the difference between that price and $2.

440 U.S. at 209.

The Court in *Royal Drug* held that because the pharmacy agreements served only to minimize the insurer's costs and did not affect its policyholders, those agreements did not "involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services." *Id.* at 214. This was because "[t]he benefit promised to Blue Shield policyholders is that their premiums will cover the cost of prescription drugs except for a $2 charge for each prescription. So long as that promise is kept, policyholders are basically unconcerned with arrangements made between Blue Shield and participating pharmacies." *Id.* Consequently, *Royal Drug* held that the agreements were not part of the "business of insurance" that is immune from antitrust scrutiny.

There are two fundamental problems with the Sixth Circuit's instant reliance on *Royal Drug*. First, pursuant to *Fabe*, the issue in this case is not whether reimbursement arrangements between an insurer and a medical provider are, themselves, part of the "business of insurance." The issue, instead, is whether Michigan's comprehensive regulation of provider agreements and reimbursement of claims is "'aimed at protecting or regulating' the performance of an insurance contract." *Fabe*, 508 U.S. at 505. Michigan's regulatory scheme controlling provider plans and reimbursement arrangements in order to limit costs is, under *Fabe*, "'aimed at protecting or regulating' the performance of an insurance contract" because it protects BCBSM's policyholders and

assures them reasonable access to quality health care, the cost of which is closely regulated.

Second, even under the more narrow analysis employed in *Royal Drug*, the same result would obtain because the "discount" pharmacy agreements at issue in *Royal Drug* are not like Michigan's statutorily mandated reimbursement arrangements. In *Royal Drug*, the Court observed that the discount pharmacy agreements were "ancillary" to the contracts between the insurer and its policyholders because they had no effect on policyholders, who were entitled to obtain prescription drugs from participating pharmacies for $2. The Court held that whatever arrangements the insurer made on its own to fulfill that obligation were no different than any other business decision. 440 U.S. at 214-216. Here, in contrast, Michigan has established a comprehensive statutory health care insurance system whereby its provisions regulating reimbursement of providers make that process an integral part of the relationship between BCBSM, its insureds, and its providers. Michigan law *requires* the use of BCBSM's provider reimbursement arrangements for all providers, and does so for the express statutory purposes of controlling health care costs and ensuring affordable and quality health care to the citizens of Michigan.

In support of its conclusion that provider reimbursement arrangements do not affect policyholder risk, and are not integrally related to BCBSM's relationship with its policyholders, the Sixth Circuit reasoned that policyholders are "largely unconcerned" with provider reimbursement arrangements "so long as the policyholders are provided with gynecological services." App. at 15a. Such a view disregards the manner in which BCBSM's regulated provider reimbursement arrangements impact the availability, quality, and cost of a myriad of health care services, and not just the

"gynecological services" that happen to be at issue in this case. To limit policyholders' interests to whether or not "gynecological services" are provided disregards today's insurance reality, with copayments, deductibles, participating providers, and regulated costs for services, all of which have an impact on the cost of insurance to the policyholder, as well as the availability of quality providers across the state of Michigan and elsewhere in this country.

Contrary to the Sixth Circuit's decision, the district court in *Everson*, 898 F. Supp. at 543, properly recognized the relationship between reimbursement arrangements and policyholders' cost of insurance and distinguished *Royal Drug* on that basis, finding it inapplicable to the court's review of the provider agreements at issue in that case:

> The [*Royal Drug*] Court determined that the pharmacy agreements served only to minimize the cost the insurer incurred fulfilling its underwriting obligations. The benefit to policyholders, however, was not affected . . . . The Court determined that the agreements did not affect the risk that the insured may suffer a financial loss arising from the purchase of prescription drugs, nor did it affect the relationship between the insurer and insured. . . .
>
> As plaintiffs argue in the instant case, under the terms of the insurance policies, the provider's discount agreements must be taken into account in calculating the policyholder's copayments. This directly affects the amount of the copayment, and, as such, the policyholder's risk of suffering financial loss.

Michigan's statutory regulation of provider reimbursement arrangements is likewise no mere cost-cutting measure. To the contrary, it directly affects the number of hospitals and doctors available to BCBSM's policyholders by establishing a network of providers who have agreed to provide health care services meeting statutorily-mandated standards of reasonable cost and quality of health care services. BCBSM's policyholders therefore have the option of obtaining services through participating providers or, alternatively, seeking medical services from a non-participating provider at a higher cost, i.e., at the risk of being required to pay more for such services than for services from a provider who has agreed to a statutorily-regulated reimbursement arrangement. Thus, the Sixth Circuit's assertion that BCBSM's policyholders are "largely unconcerned" with Michigan's regulation of BCBSM's provider reimbursement arrangements lacks merit even under *Pireno* and *Royal Drug*.

The Sixth Circuit's fundamental misunderstanding of the *Pireno* factors as applied to Michigan's comprehensive regulation of BCBSM's provider reimbursement arrangements provides yet another basis for granting certiorari in this case.

CONCLUSION

For all of the reasons stated, BCBSM respectfully requests that this Court grant its petition for a writ of certiorari.

Respectfully Submitted

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APPENDIX A

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 04-2486

[Filed June 9, 2006]

MICHAEL A. GENORD, M.D., ET AL., *Plaintiffs-Appellees*,	)
v.	)
BLUE CROSS & BLUE SHIELD OF MICHIGAN, *Defendant-Appellant*.	)

BEFORE: RYAN, CLAY, and GILMAN, Circuit Judges.

ORDER

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

APPENDIX B

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 04-2486

[Filed March 14, 2006]

MICHAEL A. GENORD, M.D., JOHN R. SANBORN, M.D., PAULA M. FISHBAUGH, M.D., ANDREA L. SCHILLER, M.D., MARK D. DYKOWSKI, M.D., JOHN E. ECKELE, M.D., and BETTY S. CHU, M.D., *Plaintiffs-Appellees*,	)
v.	)
BLUE CROSS & BLUE SHIELD OF MICHIGAN, *Defendant-Appellant*.	)

Appeal from the United States District Court for the Eastern District of Michigan at Detroit

BEFORE: RYAN, CLAY, and GILMAN, Circuit Judges.

OPINION

RONALD LEE GILMAN, Circuit Judge. The named gynecologists sued Blue Cross & Blue Shield of Michigan, alleging that Blue Cross had fraudulently denied their claims in violation of both the Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. § 1964©, and various state laws. Blue Cross moved for dismissal on the ground that the district court lacked subject matter jurisdiction because the civil RICO action was "reverse preempted" by Michigan law in accordance with a provision of a federal statute commonly known as the McCarran-Ferguson Act, 15 U.S.C. § 1012. The district court denied Blue Cross's motion, thus allowing the civil RICO claim to proceed. After the district court certified the issue for interlocutory appeal, a panel of this court exercised its discretion to grant Blue Cross's petition to have the jurisdictional issue decided on an interlocutory basis. For the reasons set forth below, we **AFFIRM** the judgment of the district court.

I. BACKGROUND

A. Michigan's Nonprofit Health Care Corporation Reform Act

Blue Cross is a "health care corporation" that is regulated extensively by the Michigan Commissioner of Insurance under the Nonprofit Health Care Corporation Reform Act, Michigan Compiled Laws §§ 550.1101-1704 (Health Care Act). Under the Health Care Act, Blue Cross is required to enter into reimbursement agreements with various medical providers. Mich. Comp. Laws § 550.1504(1) ("A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of,

health care services...."). Several provisions of the Health Care Act regulate the content of the reimbursement agreements. *See, e.g.*, Mich. Comp. Laws § 550.1502 (setting forth licensing requirements that must be met before providers are eligible to participate).

Under the Act, Blue Cross can also structure reimbursement plans for an entire class of providers, such as "medical doctors" or "pharmacies." *See* Mich. Comp. Laws §§ 550.1505-1509. Such a provider-class plan requires the approval of the Michigan Commissioner of Insurance to ensure that the plan advances the goals set forth in the Health Care Act. Mich. Comp. Laws §§ 550.1504, 550.1506 (including goals such as assuring the availability and quality of medical services). Individual provider agreements in turn contain provisions implementing such provider-class plans.

The reimbursement agreements require that the providers request payment for services rendered to Blue Cross's individual policyholders by submitting to Blue Cross a claim form containing standardized billing codes. Participating providers must agree to accept payment at the regulated rate as payment in full for their services covered under the plan. Mich. Comp. Laws §§ 550.1107(2), 550.1502(1).

B. The doctors

The doctors sued on their own behalf and on behalf of a "statewide class of persons defined as all physicians performing gynecological medical services who, from November 1, 2002, to the date of certification, provided any services to any patient insured by or who was a member or beneficiary of any plan administered by Defendant." November 1, 2002 is the date on which the doctors allege that Blue Cross changed its billing codes for gynecological

services and started systematically denying payment. At the time the district court ruled on Blue Cross's motion to dismiss, the class had not yet been certified.

C. The claims asserted by the doctors

In their amended complaint, the doctors allege four counts against Blue Cross: a civil RICO claim, an alleged violation of Michigan Compiled Laws § 500.2006 for failing to remit payment to the doctors within 45 days, and common-law claims of breach of contract and unjust enrichment. The district court had supplemental jurisdiction over the state-law claims.

In order to make out a civil RICO claim, the doctors must establish that they were "injured in [their] business or property by reason of a violation" of the criminal RICO provisions contained in 18 U.S.C. § 1962. *See* 18 U.S.C. Section 1964©. If such a claim is successful, they are entitled to treble damages and attorney fees. *Id.*

The doctors in this case claimed that, after Blue Cross changed its gynecological billing codes, it and other affiliated entities constituted an "enterprise" that, through a "common scheme, systematically denied and delayed payments due to physicians..., improperly paid reduced amounts, or made the claims process so daunting that some claims were simply abandoned or otherwise lost." According to the doctors, this scheme was perpetuated by Blue Cross falsely rejecting claims for payment through mailings and transmittals by wire (violations of 18 U.S.C. § 1341 for mail fraud and of 18 U.S.C. § 1343 for wire fraud).

D. Blue Cross's motion to dismiss

Blue Cross filed a motion under Rules 12(b)(1) and 12(b)(6) of the Federal Rules of Civil Procedure to dismiss the civil RICO claim and the Michigan Compiled Laws Section 500.2006 claim for failure to timely remit payment. The district court granted Blue Cross's motion as to the Section 500.2006 claim because the Michigan statute does not provide for a private right of action.

In its motion to dismiss the civil RICO claim, Blue Cross argued that the district court lacked subject matter jurisdiction because the McCarran-Ferguson Act prevents the invocation of a private right of action under RICO. The district court denied Blue Cross's motion, thus allowing this part of the case to proceed. On appeal, Blue Cross is challenging the district court's ruling only as to the civil RICO count and not as to the § 500.2006 count.

II. ANALYSIS

A. Standard of review

Blue Cross argues that the district court lacked subject matter jurisdiction over the doctors' civil RICO claim. We review the district court's decision on this issue de novo. *Simon v. Pfizer Inc.*, 398 F.3d 765, 772 (6th Cir. 2005) ("District Court decisions on motions to dismiss under Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6) are generally subject to a *de novo* standard of review.").

B. The McCarran-Ferguson Act and "reverse preemption"

The McCarran-Ferguson Act declares that "the business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. Section 1012(a). In the section specifically relied upon by Blue Cross, the Act provides that "no Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, ...unless such Act specifically relates to the business of insurance...." 15 U.S.C. § 1012(b). Federal law thus provides for "reverse preemption" in the realm of regulating the insurance business. *AmSouth Bank v. Dale*, 386 F.3d 763, 780-83 (6th Cir. 2004) (discussing the concept of reverse preemption under the McCarran-Ferguson Act). A general federal law that does not specifically relate to the business of insurance, therefore, cannot be construed to "invalidate, impair, or supersede" a state law enacted to regulate the insurance business. 15 U.S.C. § 1012(b).

The McCarran-Ferguson Act, however, provides an "antitrust exception" to the reverse-preemption rule. After setting forth the above rule, the Act goes on to say that the Sherman Act, the Clayton Act, and the Federal Trade Commission Act "shall be applicable to the business of insurance to the extent that such business is not regulated by State law." *Id.*

In its motion to dismiss the civil RICO claim, Blue Cross argued that Michigan's Health Care Act was enacted to regulate the business of insurance, and that the doctors' claims would "invalidate, impair, or impede" the state's law.

This claim must be analyzed under the McCarran-Ferguson Act.

Pursuant to the Act, we are required to answer three questions. The threshold question is whether the federal statute at issue "specifically relates to the business of insurance." If it does, then the McCarran-Ferguson Act by its own terms does not allow for reverse preemption. *See* 15 U.S.C. § 1012(b) (setting forth as an exception to the reverse-preemption rule a case in which the federal law in question "specifically relates to the business of insurance"). If not, then there are two remaining questions that both must be answered in the affirmative in order to conclude that application of a federal law is reverse preempted by the existence of a state law. One is whether the state statute at issue was "enacted... for the purpose of regulating the business of insurance." The other is whether the application of the federal statute would "invalidate, impair, or supersede" the state statute. *Kenty v. Bank One, Columbus, N.A.*, 92 F.3d 384, 392 (6th Cir. 1996) (setting forth the McCarran-Ferguson Act analysis).

Both parties agree that the civil RICO statute does not specifically relate to the business of insurance. *See also id.* at 391 (holding as a preliminary matter that "RICO does not 'specifically relate to the business of insurance'"). The other two questions required to be answered by the Act remain.

C. Whether the Health Care Act was "enacted for the purpose of regulating the business of insurance"

The Supreme Court in *United Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129, 102 S. Ct. 3002, 73 L. Ed. 2d 647 (1982), addressed the antitrust exception of the McCarran-Ferguson Act and set forth three criteria for what

constitutes the "business of insurance": (1) "whether the practice has the effect of transferring or spreading a policyholder's risk," (2) "whether the practice is an integral part of the policy relationship between the insurer and the insured," and (3) "whether the practice is limited to entities within the insurance industry." Affirmative responses to these criteria indicate that the practice *is* the "business of insurance," but "none of these criteria is necessarily determinative in itself." *Id.*

Eleven years later, in *United States Department of Treasury v. Fabe*, 508 U.S. 491, 501-05, 113 S. Ct. 2202, 124 L. Ed. 2d 449 (1993), the Supreme Court discussed the general rule of the McCarran-Ferguson Act, asking whether a state's insolvency-priority statute could be classified as a law "enacted... for the purpose of regulating the business of insurance." The Court held that the Act's general rule covers a "broad category of laws... [that] necessarily encompasses more than just the 'business of insurance.'" *Id.* at 505.

In *Owensboro National Bank v. Stephens*, 44 F.3d 388 (6th Cir. 1994), this court explained the interaction between *Pireno* and *Fabe*. The court stated that "whether a particular activity is part of the 'business of insurance' is, of course, a separate question from whether a state law was 'enacted... for the purpose of regulating the business of insurance.'" *Id.* at 392. The *Pireno* inquiry concerning whether an activity is part of the "business of insurance," however, can inform the *Fabe* inquiry of whether a law was "enacted... for the purpose of *regulating* the business of insurance." (emphasis added). *Stephens* thus held that "to have been 'enacted... for the purpose of regulating the business of insurance,' [the state law] must possess the aim of regulating activities that meet the *Pireno* criteria" set forth above. *Id.* Each *Pireno* criteria will therefore be addressed in turn.

1. Does the Health Care Act have the aim of regulating a practice that has the effect of transferring or spreading policyholder risk?

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 211, 99 S. Ct. 1067, 59 L. Ed. 2d 261 (1979), the Supreme Court was faced with the question of whether certain agreements between Blue Shield (operated by Group Life) and various pharmacies constituted the "business of insurance." If someone insured by Blue Shield purchased a prescription drug from a pharmacy that had signed a "pharmacy agreement" with Blue Shield, the insured was required to pay only $2.00 for each prescription. *Id.* at 209. Blue Shield would then pay the balance of the prescription cost to the pharmacy. *Id.* Pharmacies without "pharmacy agreements" brought an antitrust action, alleging violations of the Sherman Act. *Id.* at 207. The Court held that the pharmacy agreements were not part of the "business of insurance" because they did not transfer or spread policyholder risk, but "served only to minimize the costs Blue Shield incurred in fulfilling its underwriting obligations." *Id.* at 213-14. "Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the 'business of insurance.'" *Id.* at 214.

Turning to the present case, the doctors' allegations deal with the denial and delay of reimbursement payments due them for services rendered. Their claims, as in *Royal Drug*, relate to how a company like Blue Cross goes about making health care services available to its policyholders. In *Royal Drug*, Blue Shield provided $2.00 prescriptions to its policyholders by way of pharmacy agreements. Here, the Health Care Act allows Blue Cross to make gynecological services available to its policyholders by way of

reimbursement agreements with doctors that require the doctors to send their invoices to Blue Cross containing the disputed billing codes. Neither type of agreement (the pharmacy agreement or the billing-code-reimbursement agreement) can be said to transfer or spread policyholder risk. *Royal Drug*, 440 U.S. at 213. The first *Pireno* criterion is therefore unsatisfied on the facts of this case.

2. ***Does the Health Care Act have the aim of regulating a practice that is an integral part of the policy relationship between the insurer and the insured?***

Fabe is instructive with respect to this second *Pireno* criterion. In *Fabe*, the Supreme Court addressed the application of the McCarran-Ferguson Act to the clash between a state bankruptcy statute and the federal Bankruptcy Code over the priority of payments when an insurance company is liquidated. *Fabe*, 508 U.S. at 493, 502. First priority is to the United States Government under the federal bankruptcy provision, whereas the state statute prioritizes administrative expenses, certain wage claims, policyholders' claims, and claims of general creditors above claims of the federal government. *Id.* at 495-96. The Court focused on the provisions of the state bankruptcy statute that go to the "actual performance of an insurance contract" because those provisions are an "essential part of the 'business of insurance.'" *Id.* at 505, 509 n.8. According to the Court, the preference for the policyholders' claims was enacted "'for the purpose of regulating the business of insurance' to the extent that it serves to ensure that, if possible, policyholders ultimately will receive payment on their claims." *Id.* at 506. The administrative-expenses priority also falls into that category because "the expenses of administering the insolvency proceeding [are] reasonably necessary to further the goal of protecting policyholders." *Id.* at 509. As to "the

preferences conferred upon employees and other general creditors, however, [they] do not escape pre-emption because their connection to the ultimate aim of insurance is too tenuous." *Id.*

Fabe thus stands for the proposition that, in determining what is integral to the policy relationship, the focus is on the extent to which the state law furthers the interests of the policyholders. *Royal Drug* also supports that conclusion, noting that Blue Shield had promised its policyholders to provide them with prescription drugs at a cost of $2.00 per prescription, and "so long as that promise is kept, policyholders are basically unconcerned with arrangements made between Blue Shield and participating pharmacies." *Royal Drug*, 440 U.S. at 214. What constitutes an "integral part of the policy relationship" is therefore determined by reference to the interests of the policyholders.

Recognizing that the focus is on the interests of the policyholders, Blue Cross argues that, because the billing arrangements between it and the doctors may result in a lower health care cost to the public, the arrangements are an integral part of the policy relationship. But this is an argument that the *Royal Drug* Court considered and rejected:

> At the most, the petitioners have demonstrated that the Pharmacy Agreements result in cost savings to Blue Shield which may be reflected in lower premiums if the cost savings are passed on to policyholders. But, in that sense, every business decision made by an insurance company has some impact on its reliability, its rate making, and its status as a reliable insure.... Such a result would be plainly contrary to the statutory language, which exempts "the business of

> insurance" and not the "business of insurance companies."

Id. at 216-17.

In this case, Blue Cross fails to explain how the Health Care Act's regulation of the billing-code invoicing arrangement with health care providers furthers the interests of the policyholders. Contrary to Blue Cross's argument, this is not a case like *Fabe* where the state law requires the insurance company to pay the claims of the *policyholders* (a true case of "actual performance" of an insurance contract). The claims in dispute here are those of the medical providers, not the policyholders. This case is therefore more like *Royal Drug* because the policyholders are unconcerned with the reimbursement arrangements between Blue Cross and the doctors so long as they receive medical treatment as contemplated by their agreement with Blue Cross. *See Royal Drug*, 440 U.S. at 214. Because the provider-agreement and reimbursement provisions of the Health Care Act do not have the aim of regulating a practice that is an integral part of the policy relationship between the insurer and the insured, *Pireno*'s second criterion is unsatisfied on the facts of this case.

3. Does the Health Care Act have the aim of regulating a practice that is limited to entities within the insurance industry?

In *Pireno*, the Supreme Court noted that this inquiry is not dispositive, but nonetheless is "mandated by the *Royal Drug* analysis." *Pireno*, 458 U.S. at 133. The Court held that there is not a per se rule that practices involving noninsurance-industry entities always fall outside of the "business of insurance." *Id.* Rather, courts should take this

factor into account because "arrangements between insurance companies and parties outside the insurance industry can hardly be said to lie at the center of [the] legislative concern" of "protecting *intra*-industry cooperation in the underwriting of risks." *Id.* (citation and quotation marks omitted).

Blue Cross does not argue that the doctors involved in this litigation are "entities within the insurance industry." And, as set forth in Part II.C.1. above, the billing arrangements between Blue Cross and the doctors do not involve the spreading of risk. The provisions of the Health Care Act relating to those billing arrangements therefore "can hardly be said to lie at the center of... legislative concern." *Id.* As a result, the third *Pireno* criterion is also unsatisfied.

In sum, none of the three *Pireno* criteria are met in this case. The billing arrangements do not transfer or spread policyholder risk, but instead allow Blue Cross to furnish gynecological services to its policyholders by way of third-party providers. The parts of the Health Care Act at issue are also not an integral part of the policy relationship because the policyholders are largely unconcerned with how the doctors get paid, so long as the policyholders are provided with gynecological services. And finally, because the doctors are not entities within the insurance industry, the Health Care Act provisions relating to their billing arrangements do not "lie at the center of... legislative concern" of the McCarran-Ferguson Act. *Id.*

D. Whether the civil RICO claim would "invalidate, impair, or supersede" Michigan's Health Care Act

The provisions of the Health Care Act that are at issue simply do not "possess the aim of regulating activities that meet the *Pireno* criteria." *Stephens*, 44 F.3d at 392. Because

the reimbursement provisions were not "enacted... for the purpose of regulating the business of insurance," we need not reach the remaining McCarran-Ferguson-Act issue of whether the application of the civil RICO statute "invalidates, impairs, or supersedes" the Health Care Act. *See* 15 U.S.C. Section 1012(b). Blue Cross's claim of reverse preemption therefore fails and the doctors' civil RICO claim should be allowed to proceed.

III. CONCLUSION

For all of the reasons set forth above, we **AFFIRM** the judgment of the district court.

APPENDIX C

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 04-2486

[Filed March 14, 2006]

MICHAEL A. GENORD, M.D., JOHN R. SANBORN, M.D., PAULA M. FISHBAUGH, M.D., ANDREA L. SCHILLER, M.D., MARK D. DYKOWSKI, M.D., JOHN E. ECKELE, M.D., and BETTY S. CHU, M.D., *Plaintiffs-Appellees*,	)
v.	)
BLUE CROSS & BLUE SHIELD OF MICHIGAN, *Defendant-Appellant*.	)

Appeal from the United States District Court for the Eastern District of Michigan at Detroit

BEFORE: RYAN, CLAY, and GILMAN, Circuit Judges.

JUDGMENT

THIS CAUSE was heard on the record from the district court and was argued by counsel.

IN CONSIDERATION WHEREOF, it is ORDERED that the judgment of the district court is AFFIRMED.

ENTERED BY ORDER OF THE COURT

/s/ _____
Leonard Green, Clerk

APPENDIX D

UNITED STATES COURT DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 03-CV-72950-DT

[Filed July 29, 2004]

MICHAEL A. GENORD, M.D., ET AL., *Plaintiffs*,	)
v..	)
BLUE CROSS & BLUE SHIELD OF MICHIGAN, *Defendant*.	)

OPINION AND ORDER GRANTING IN PART AND DENYING IN PART DEFENDANT'S MOTION TO DISMISS

This matter is presently before the court on defendant's motion to dismiss the first amended complaint pursuant to Fed. R. Cir. P. 12(b)(1) and 12(b)(6). The issues have been fully briefed and the court has heard oral argument. For the reasons stated below, the court shall grant the motion in part and deny it in part.

Plaintiff Michael Genord, M.D., and six other gynecologists allege that defendant Blue Cross and Blue Shield of Michigan ("BCBSM") has failed to pay their legitimate claims for gynecological services. Plaintiffs indicate they are bringing the case on their own behalf, as well as on behalf of more than 5,000 other similarly situated Michigan gynecologists. Although they have not yet moved for class certification, plaintiffs allege in ¶ 12 of the amended complaint that the class should be defined as "all physicians performing gynecological medical services who, from November 1, 2002, to the date of certification, provided services to any patient insured by or who was a member or beneficiary of any plan administered by Defendant."

Plaintiffs allege that in the spring of 2002 defendant changed its billing codes for gynecological services. Plaintiffs allege that although they complied with defendant's instructions regarding the use of the new codes, defendant has routinely denied legitimate claims on the grounds that the incorrect codes were being used, or delayed payment unjustifiably, or "made the claims process so daunting that some claims were simply abandoned." Plaintiffs indicate that they verified the correct codes were being used and then resubmitted the claims, which were denied again. Plaintiffs do not quantify the amount of the allegedly unpaid claims. They seek unspecified damages for the amount of unpaid claims, plus the costs associated with tracking and resubmitting claims.

Federal subject matter jurisdiction is based on Count I of the amended complaint in which plaintiffs assert a claim under the Racketeer Influenced and Corrupt Organizations Act

("RICO"), 18 U.S.C. §§ 1961, et seq.[1] Plaintiffs allege that the denial and underpayment of their claims is being perpetuated by "the BCBSM Enterprise," consisting of BCBSM and the companies which are involved in processing claims.[2] Plaintiffs allege that defendant uses this enterprise to systematically deny or delay or underpay claims, and that RICO is violated because defendant has engaged in many instances of mail and wire fraud, which plaintiffs argue come within RICO's definition of racketeering activity.

Paragraph 25 of the amended complaint makes the following allegations regarding the manner in which the BCBSM Enterprise operates:

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[1] Plaintiffs also assert claims for breach of contract (Count II), violation of M.C.L. § 500.2006 (Count III), and unjust enrichment (Count IV).

[2] Para. 23 of the amended complaint alleges that the following entities constitute the BCBSM Enterprise:

> (1) Defendant and its subsidiaries that provide healthcare services to tens of thousands of enrollees in various healthcare plans statewide; (2) other health insurance companies not named as defendants; (3) HBOC McKesson and other third-party entities which develop claims processing systems or components for BCBSM; (4) BCBSM Claims Support and all other third-patty entities utilized by Defendant to facilitate claims processing; and (5) Electronic Data Interchange ('EDI'). These entities are associated in fact as part ofa healthcare network with the common purpose of facilitating medical services, through coding procedures and claims processing, and earning profits from providing those services.

25. In order to retain monies and interest owed physicians in the manner set forth above, Defendant needs a system that allows it to manipulate and control reimbursements to physicians and conceal the manner m which it is done. The BCBSM Enterprise provides Defendant with that system and ability, and their control of and participation in it is necessary for the successful operation of the scheme. Defendant controls and operates the BCBSM Enterprise and conducts and participates in the Enterprise's affairs as follows:

A. By designing, developing, and implementing new computer systems to process new coding guidelines and claims processing procedures to be used in order to reimburse provider claims;

B. By disseminating and distributing those new coding guidelines and claims processing information through meetings, correspondence, and publications, including The Record, at which attendees and recipients share and receive billing information;

C. By approving, engaging, and requiring coding guidelines, standards and forms to be used by its subsidiaries, third-party entities, claims support, EDI, and others, instructions, such as through The Record and other correspondence, to systematically and routinely deny clean claims;

D. By dictating the use of those coding guidelines, standards and instructions within the new

computer system to systematically mad routinely deny and delay payment of clean claims.

E. By directing, engaging and paying HBOC McKesson and other third-party entities to develop the automated systems for editing and manipulating the claims information which systematically and routinely deny clean claims; and

F. By dictating and supporting BCBSM Claims Support, EDI and other third-party entities as a common entry point for physician claim data to assist Defendant in processing claims in a coordinated fashion in which they axe systematically and routinely denied.

Plaintiffs further allege that BCBSM committed wire and mail fraud by making false representations in "agreements, manuals, guidelines, instructions, newsletters, correspondence and similar information related to the new coding scheme." Amended Complaint ¶ 26. Specifically, plaintiffs allege:

27. The false and fraudulent mater and misrepresentations sent by Defendant via the Postal Service or wire and on which Plaintiffs relied, include:

A. **The April 2002 Issue Of The Record (Defendant's Physician Publication)**. BCBSM notified its providers of changes in coding procedure that had gone into effect on November 27, 2001, for annual gynecological exams, requiring providers to begin using an

S code combined with an E&M code, otherwise, providers would not be reimbursed; despite these representations to providers that BCBSM's new system was ready to accept the new codes and therefore pay provider claims, clean claims submitted under these codes were systematically and routinely rejected by BCBSM;

B. **The January 2003 Issue Of The Record.** BCBSM notified providers that it would start accepting the Q code for payment beginning September 2002; however, despite these representations that BCBSM's system would accept this code and pay provider claims, BCBSM's system did not accept this code and clean claims submitted under this code were systematically and routinely rejected by BCBSM;

C. **Correspondence From BCBSM.** Sonia A. Parks, M.D., a BCBSM employee in the Physician's Ombudsman Department, sent a letter to Plaintiff Genord dated February 7, 2003, again representing that if the physicians followed BCBSM billing codes and instructions, they would be timely paid. Relying on these further representations and requirements to be followed in order to have claims reimbursed, Plaintiffs continued to submit claims accordingly. These clean claims, however, were still systematically and routinely rejected by BCBSM.

D. **Additional Correspondence.** Additional correspondence from BCBSM which concealed or failed to disclose that BCBSM would and did use techniques, procedures, systems and software that deprived or delayed Plaintiffs and class members of payment on clean claims submitted in accordance with BCBSM instructions, representations, and requirements;

E. **A Letter From BCBSM Vice President Of Medical Affairs.** Chief Medical Officer Thomas L. Simmer, M.D. of BCBSM sent a letter to Plaintiff Genord dated March 2003 stating that Defendant has worked diligently in correcting processing problems which were allegedly causing the rejections. However, Defendant failed to rectify the problem represented [sic], and Defendant continued for several months to systematically and routinely reject clean claims submitted and resubmitted by Plaintiffs in accordance with Defendant's continued instructions to follow the new coding procedures; and

F. **Provider Vouchers.** Provider vouchers received by mail and wire from BCBSM and its third-party entities that facilitated the claims process, systematically and routinely contained false rejections of clean claims when BCBSM was well aware after all of the complaints by physicians that the rejections created systematically and routinely by the computer system were false rejections.

28. Defendant specifically intended to deceive Plaintiffs mad the class members when it knowingly transmitted, and continued to transmit, these misrepresentations, acts of concealment and failures to disclose through the mail and wires for the purpose of obtaining or retaining for a period of time their property for Defendant's gain.

30. Defendant knew, particularly after months of correspondence, telephone calls and other forms of complaints by physicians, that its processing system would not properly identify, approve and pay clean claims. Yet, Defendant proceeded to implement and operate the system and continued to require Plaintiffs to submit claims and resubmit rejected claims in accordance with the faulty system's coding guidelines despite its knowledge and the misrepresentations to Plaintiffs that the system problems were being diligently corrected.

Defendant's Motion to Dismiss

Defendant seeks dismissal for lack of subject matter jurisdiction and for failure to state a claim. Defendant's main argument is that subject matter jurisdiction is lacking because the RICO claim is barred by the McCarran-Ferguson Act, 15 U.S.C. § 1012, which states:

(a) State regulation

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating, the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C.A. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

(Emphasis added.) Defendant argues that the highlighted clauses bar plaintiffs' RICO claim because (1) RICO does not "specifically relate[] to the business of insurance"; and (2) if RICO is construed in the manner proposed by plaintiffs, then the Michigan statutory scheme that regulates BCBSM[3] will, in effect, be invalidated, superseded or impaired because that scheme specifies procedures by which claims are to be paid and payment disputes are to resolved. Plaintiffs agree that RICO does not specifically relate to the business of insurance. However, they argue that the McCarran-Ferguson Act does not apply, and does not bar their RICO claim, because the Michigan statute was not "enacted... for the purpose of regulating the business of insurance."

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[3] This is the Michigan Nonprofit Health Care Corporation Reform Act (the "'Nonprofit Act"), M.C.L. §§ 550.1101, et seq., passed in 1980.

Having reviewed the cases and considered the parties arguments, the court believes that plaintiffs' RICO claim is not barred by the McCarran-Ferguson Act because (1) the Michigan Nonprofit Health Care Corporation Reform Act (the "Nonprofit Act"), which regulates BCBSM, was not "enacted... for the purpose of regulating the business of insurance," and (2) the provider contracts at issue in this case are not part of the "business of insurance."

Regarding the first point, the Nonprofit Act itself does not indicate that it has anything to do with regulating the business of insurance. According to M.C.L. § 550.1102:

> (1) It is the purpose of and intent of this act, and the policy of the legislature, to promote an appropriate distribution of health care services for all residents of this state, to promote the progress of the science and art of health care in this state, and to assure for nongroup and group subscribers, reasonable access to, and reasonable cost and quality of, health care services, in recognition that the health care financing system is an essential part of the general health, safety, and welfare of the people of this state. Each corporation subject to this act is declared to be a charitable and benevolent institution and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.
>
> (2) It is the intention of the legislature that this act shall be construed to provide for the regulation and supervision of nonprofit health care corporations by the commissioner of insurance so as to secure for all of the people of this state who apply for a certificate, the opportunity for access to health care services at a fair and reasonable price.

> (3) It is the public policy of this state that, in the interest of facilitating access to health care services at a fair and reasonable price, an alternate, expeditious, and effective procedure for the resolution of issues and the maintenance of administrative appeals relative to provider class plans be established and utilized, and to that end, the provisions of this act regarding administrative review of those provider class plans shall be construed so as to minimize uncertainty and delays.

Thus, the stated legislative purpose of the Nonprofit Act has nothing to do with regulating the business of insurance. To the contrary, the purpose is to "facilitat[e] access to health care services."

Further, the Nonprofit Act specifically states that "[a] health care corporation shall not be subject to the laws of this state with respect to insurance corporations, except as provided in this act." M.C.L. § 550.1201(4). A healthcare corporation under this statute "is declared to be a charitable and benevolent institution," the funds and property of which are exempt from state and local taxation. See M.C.L. Section 550.1201(5). The Nonprofit Act also states that "[a] health care corporation shall not market or transact... any type of insurance described in... sections 500.600 to 500.644 of the Michigan Compiled Laws.[4]

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[4] These sections cover life insurance, disability insurance, property insurance, marine insurance, inland navigation and transportation insurance, legal expense insurance, automobile insurance, casualty insurance, automobile passenger and liability coverage, surety and fidelity insurance, and reinsurance.

The Michigan Insurance Code defines "insurer" as "any individual, corporation, association... and any other legal entity, engaged or attempting to engage in the business of making insurance or surety contracts." M.C.L. § 500.106. Clearly, defendant does not fall within this definition. The Nonprofit Act states that a healthcare corporation's name "shall not include the words insurance, casualty, surety, health and accident, mutual or other words descriptive of the insurance or surety business," M.C.L. § 50.1202(1)©, and that the purpose of a health care corporation, which must be indicated in its articles of incorporation, is to provide "access to coverage for health care services at a fair and reasonable price." M.C.L. § 50.1202(1)(d)(ii). See also M.C.L. Section 550.I 102(1).

Michigan courts have noted the distinction between an insurance company and a healthcare corporation under the Nonprofit Act. The Michigan Supreme Court has held that "BCBSM is a unique statutory creation, distinct from a private insurance company in that it is not carried on as an insurance business for profit but rather it provides a method for promoting the public health and welfare in assisting persons to budget health care costs." Blue Cross Blue Shield of Mich. v. Governor, 422 Mich. 1, 14 (1985) (citations, internal quotation marks and ellipses omitted). The Michigan Court of Appeals has stated that "BCBSM is not an insurance company, but is a health care corporation." Blue Cross Blue Shield of Mich. v. Comm'r of Ins., 179 Mich. App. 246, 252 (1989). See also Opinion of the Michigan Attorney General, No. 7115, July 30, 2002, p. 2 ("The [Nonprofit] Act's provisions clearly demonstrate the Legislature's intent to distinguish BCBSM from an insurance business and to eliminate any confusion in identity with that of an insurance company.").

The Nonprofit Act itself, and the cases which have considered it, make clear that the Nonprofit Act does not constitute a "law enacted by a[] State for the purpose of regulating the business of insurance." The Michigan legislature has specifically indicated that the Nonprofit Act is meant "to provide for the regulation and supervision of nonprofit health care corporations," not to regulate or supervise insurance companies or the business of insurance.

Furthermore, the specific conduct at issue in this case cannot be considered part of the "business of insurance" within the meaning of the McCarran-Ferguson Act. As noted above, plaintiffs are providers of medical services who allege that defendant has repeatedly rejected their legitimate claims seeking payment for services provided to BCBSM subscribers. The Supreme Court has held that the McCarran-Ferguson Act, in referring to the "business of insurance," intended to focus on "the relationship between the insurance company and the policyholder." United States Dept. of Treasury v. Fabe, 113 S. Ct 2202, 2208, quoting SEC v. Nat'l Sec., Inc., 393 U.S. 453,460 (1969). In Fabe, the plaintiff was the state's superintendent of insurance who was acting as the liquidator to wind up the affairs of an insolvent insurance company. The liquidator brought a declaratory judgment action to establish the priority of various claims. One of the creditors was the United States. A federal statute gave top priority to the United States, whereas the Ohio liquidation statute, which applied only to insolvent insurance companies, gave the United States and other government claimants a lower priority. The issue was whether the federal statute applied, or whether its application was barred by the McCarran-Ferguson Act. The Court held that the Ohio statute was a law "enacted for the purpose of regulating the business of insurance" insofar as it regulated the relationship between the insurance company and its policyholders, which

the Court had previously characterized as the "clear... focus" of the phrase "business of insurance." Id. at 2208. The Ohio priority statute had this effect "to the extent that it serves to ensure that, if possible, policyholders ultimately will receive payment on their claims." Id. at 2210. However, the Court also held that the Ohio statute was not enacted for the purpose of regulating the business of insurance "[t]o the extent that it is designed to further the interests of other creditors," as opposed to policyholders. Id. at 2212. Likewise, the Nonprofit Act's regulation of the contracts in the present case is not regulation of the business of insurance because the contracts are not between an insurance company and its policyholders.

Further support for the court's conclusion is found in Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979). In that case, an insurance company entered into contracts with pharmacies whereby the pharmacies would sell prescription drugs to policyholders for $2 and obtain the balance of the drugs' cost from the insurance company. Competing pharmacies who were not included in this arrangement brought an antitrust action against the insurance company and the participating pharmacies. The issue was whether these "pharmacy agreements" were included within the business of insurance and therefore subject to the exception set forth in the second clause of §2(b) of the McCarran-Ferguson Act. In concluding that the agreements did not constitute the business of insurance, the Court stated:

> The Pharmacy Agreements thus do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, Blue Shield effectively reduces the total amount it must pay to its

policyholders. The Agreements thus enable Blue Shield to minimize costs and maximize profits. Such cost-saving arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."

* * *

Another commonly understood aspect of the business of insurance relates to the contract between the insurer and the insured. In enacting the McCarran-Ferguson Act Congress was concerned with: "The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement - these were the core of the 'business of insurance.' Undoubtedly, other activities of insurance companies relate to closely to their status as reliable insurers that they too must be placed in the same class. But whatever the exact scope of the statutory term, it is clear where the focus was - it was on the relationship between the insurance – company and the policyholder." SEC v. National Securities, Inc., supra, at 460, 21 L Ed 2d 668, 89 S Ct 564.

The Pharmacy Agreements are not "between insurer and insured." They are separate contractual arrangements between Blue Shield and pharmacies engaged in the sate and distribution of goods and services other than insurance ....

At most, the petitioners have demonstrated that the Pharmacy Agreements result in cost savings to Blue Shield which may be reflected in lower premiums if

> the cost savings are passed on to policyholders. But, in that sense, every business decision made by an insurance company has some impact on its reliability, its ratemaking, and its status as a reliable insurer.

Id. at 214-17.

The court is also persuaded by Judge Moreno's thoughtful analysis of this issue in In re Managed Care Litigation, 298 F.Supp.2d 1259 (S.D. Fla. 2003). In that multidistrict litigation, the plaintiffs are physicians "who allege that the managed care company defendants... engaged in a pattern of failing to pay claims in full and in a timely manner," in violation of RICO and other statutes. Id. at 1271. The court denied defendants' motion to dismiss the RICO claim under McCarran-Ferguson because the provider contracts are not the business of insurance:

> Moreover, the [second amended complaint] alleges practices which clearly do not deal with the transfer or spreading of a policy-holder's risk. The provider contracts are simply business contracts that allow Defendants to carry out their obligations to their insureds. While some type of provider agreement may be necessary for the Defendants' plans to exist, "it does not follow that because an agreement is necessary to provide insurance, it is also the 'business of insurance.'" *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205,214, n. 9, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979). Even though the provider contracts might inure to the benefit of policyholders, they are still not part of the core insurance policy.

* * *

Defendants also encourage the Court to adopt a more expansive interpretation of the "business of insurance." Citing *United States Dep't of the Treasury v. Fabe,* 508 U.S. 491,506, 113 S.Ct. 2202, 124 L.Ed.2d 449 (1993), the Defendants contend that the reach of the Act is not confined to the business of insurance; rather, the inquiry is focused on whether application of federal law impairs, interferes or conflicts with a State's broad regulatory authority over the business of insurance. *Fabe,* 508 U.S. at 505, 113 S.Ct. 2202. Defendants point to *Fabe's* language which interprets the Act to preclude any suit that seeks to supplant state efforts directly or indirectly "aimed at protecting or regulating" the performance of an insurer's obligations or ensuring that policyholders "ultimately will receive payment." *Id.* at 506, 113 S.Ct. 2202.

Nothing in *Fabe,* however, suggests that the Act sweeps within its scope all laws that affect insurance companies. Indeed, the Supreme Court in *Fabe* supported the interpretation of the "business of insurance" as focusing on the relationship between the insurance company and the policyholder. Here, Plaintiffs' relationship to the insurer is ancillary to the actual insurance contract itself. *See Royal Drug,* 440 U.S. at 216, 99 S.Ct. 1067. The contracts of insurance were between Defendants and the insureds, not between Defendants and the individual providers (service agreements). Accordingly, the Court finds

> that the relationship between insurers and providers falls outside the "business of insurance" and thus the Act does not pose a preemption issue.

298 F.Supp.2d at 1284-85 (some citations and footnotes omitted).

For these reasons, the court concludes that the Nonprofit Act is not a "law enacted... for the purpose of regulating the business of insurance," and that the service provider contracts at issue in this case are not part of the "business of insurance," within the meaning of the McCarran-Ferguson Act. Accordingly, plaintiffs' RICO claim is not "reverse preempted," and defendants' motion to dismiss this claim on this basis is denied.

The court shall also deny defendant's motion insofar as it seeks dismissal of the RICO claim based on various alleged pleading defects. For example, defendant argues that plaintiffs have not adequately alleged injury, that they have not alleged mail mad wire fraud with sufficiently particularity, and that the RICO enterprise and defendant's control thereof are not adequately pled.

While defendant correctly argues that "courts should eliminate frivolous RICO claims at the earliest state of litigation, Durant v. ServiceMaster Co., 159 F.Supp.2d 977, 981 (E.D. Mich. 2001)," the present case does not fall into this category. The court is satisfied that the amended complaint puts defendant on fair notice as to the nature of the alleged fraud, injury, and composition and control of the RICO enterprise. Whether plaintiff can prove the allegations is a matter to be tested on summary judgment after full discovery. Defendant's motion to nip the RICO claim at the pleading stage is denied.

Finally, defendant argues that plaintiffs' claim under M.C.L. § 500.2006 (Count III of the amended complaint) should be dismissed because that statute does not create a private right of action for health professionals. Section 500.2006, which requires timely payment of claims, states:

> (12) A health professional, health facility, or health plan alleging that a timely processing or payment procedure under subsections (7) to (11) has been violated may file a complaint with the commissioner on a form approved by the commissioner and has a right to a determination of the matter by the commissioner or his or her designee. This subsection does not prohibit a health professional, health facility, or health plan from seeking court action. A health plan described in subsection (14)(c)(iv) is subject only to the procedures and penalties provided for in subsection (13) and section 402 of the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1402, for a violation of a timely processing or payment procedure under subsections (7) to (11).

Subsection 14(c)(iv), in turn, defines health plan as including "[a] health care corporation for benefits provided under a certificate issued under the nonprofit health care corporation reform act..." Therefore, if defendant as failed to timely pay claims, it "is subject only to the procedures and penalties provided for in subsection (13) and section 402 of the nonprofit health care corporation reform act." Subsection 13 states: "In addition to any other penalty provided for by law, the commissioner may impose a civil fine of not more than $1,000.00 for each violation of subsections (7) to (11) not to exceed $10,000.00 in the aggregate for multiple violations." And § 402 of the Nonprofit Act, which prohibits a health care

corporation from doing various things, including delaying payment of claims, creates a private right of action only for "an aggrieved member," not an aggrieved provider. M.C.L. § 1402(11).

Clearly, plaintiffs' remedy under § 500.2006 is limited to filing a complaint with the insurance commissioner. The statute creates no private fight of action for healthcare professionals. Accordingly, the court shall grant defendant's motion to dismiss Count III.

For these reasons,

IT IS ORDERED that defendant's motion to dismiss is granted in part and denied in part. The motion is granted as to Count III, but otherwise denied.

IT IS FURTHER ORDERED that defendant's motion for protective order shall be heard on Wednesday, August 25, 2004, at 2:00 p.m. At that time, the court shall also conduct a Rule 16(b) scheduling conference.

/s/ Bernard A. Friedman
BERNARD A. FRIEDMAN
CHIEF U.S. DISTRICT JUDGE

Dated: 7/29/04
Detroit, Michigan

APPENDIX E

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN (Detroit)

No. 02-70769

[Filed March 23, 2004]

MICHAEL A. GENORD, M.D., ET AL., *Plaintiffs*,	)
v.	)
BLUE CROSS & BLUE SHIELD OF MICHIGAN, *Defendant*.	)

TRANSCRIPT OF PROCEEDING
MOTION TO DISMISS

[p.2]

THE CLERK: Calling Case No. 72950 Genord v. Blue Cross and Blue Shield of Michigan.

THE COURT: Appearances for the record.

MR. FINK: Yes. Joe Fink with Blue Cross, and with me today is John Gross.

MR. GROSS: Good afternoon.

MR. HORTON:- William Horton on behalf of the Plaintiff, and with me is Mr. Watson.

THE COURT: Does somebody want to use the Elmo projector? I set up the screen; you're more than welcome.

MR. HORTON: Biggest screen I've seen. It might take a second. When I have an opportunity --

THE COURT: I can move to see it.

MR. HORTON: Thank you, your Honor.

THE COURT: Okay. This is the Defendant's motion and it's a motion to dismiss. You may proceed.

MR. FINK: Your Honor, I would not normally give any factual cases for 12(d) --

[p. 3]

THE COURT : Just make it quick.

MR. FINK: I'll give a short statement.

THE COURT : I appreciate it, and I'm sorry to keep everyone waiting. Somebody has to be first and somebody has to be last, so I apologize. You may proceed.

MR. FINK: Thank you, your Honor. This is an action filed by physicians against Blue Cross as a class action. It asserts that, among other things, the claim under the Racketeer Influenced and Corrupt Organizations Act, commonly known as RICO, which is a federal statute affording what some courts have termed the incredible advantage of remedy.

The Plaintiffs have alleged, and this is clearly summary, your Honor, and I take it now verbatim from paragraph 21 of –

THE COURT : I appreciate it.

MR. FINK: -- Plaintiffs' Amended Complaint, which is a fair summary, I believe, and that paragraph reads in full, "In addition to breaching the contractual and statutory duties, Defendant, on its own and as part of a common scheme to systematically deny and delay payments to the physicians so they were not paid in a timely manner for the covered services and properly paid reduced amounts to make the claims process so daunting [p. 4] that some claims were simply abandoned or otherwise lost. This is done through an enterprise that denies payments to physicians based on processing bills using an automated program which manipulates standard coding practices to artificially deny and delay payment."

Blue Cross here has moved to dismiss the amended complaint, initially under Rule 12(b) I, due to the fact that the claim is outside this Court's jurisdiction, and that under the doctrine of reverse preemptive -- the McCarran-Ferguson Act, which provides no acts of Congress shall be construed to invalidate, impair or supercede any law enacted by any state for the purpose of regulating the business of insurance unless

such act specifically relates to the business of insurance. In other words, your Honor, this complaint, based upon reason, is outside of the jurisdiction of this Court based upon the reverse preemptive doctrine, based on the McCarran-Ferguson Act. There are a myriad of cases under the 12(b)6 basis, only two of which I will discuss in oral arguments today.

With that preface, your Honor, I would like to move slightly not outside of our papers, but rather to shift emphasis a bit from our papers, because I believe the value of oral argument of anything is to go beyond that which I've offered to you.

THE COURT: I appreciate that, because I believe [p. 5] you are correct. I can read everything. It's the feel that I need from those things that I can't read, and you're absolutely right. That's why I hold oral arguments as often as I possibly can. And I have read everything, and the truth of the matter is, when we reach the appropriate point, I have a substantial different perspective of this case than either one of you have argued and we'll talk about that in a minute. Maybe you'll cover that area.

MR. FINK: I hope I do. If you'd like to give me a minute before I begin, I'll make sure I do.

THE COURT: I'd like to hear what you have to say because I've been in discussion with my law clerk concerning this particular issue, but I want to hear what you say and I want to share it with both of you. It's something that I have to share with you in a second. Let me hear what you have to say that is not necessarily articulated in your papers.

MR. FINK: The matters that I raised are touched upon in our papers. It's a matter of emphasis, I believe, your Honor. I have in my hand here a 196-page statute. This is a regulatory context of the business of insurance for health care in the State of Michigan. This is, I warn to the Court, with one exception, to my knowledge, perhaps in the State of Massachusetts, the [p. 6] most detailed, comprehensive delineation and control of the business of insurance in the United States.

THE COURT: And that's the Michigan --

MR. FINK: State law. This is the Michigan Act.

THE COURT: Let me tell you where I'm coming from, both of you, so you understand. The way I read the statute that we're talking about here -- first of all, I agree wholeheartedly with this rule. An insurance company, or whatever that says in the Ferguson Act -- I have it right here, how they define it, "Purpose of regulating business for insurance." My question to both of you is that the act that's in question here, which is the Michigan Nonprofit Health Care Corporation Act, which is 550.1101, specifically says that it's not an insurance company -- it's not insurance -- paragraph -- I had my clerk type it up. In my own notes, I had it perfect. Hold on one second. I'm reading from section -- I thought it was four. There it is. Four. Here it is.

"Nonprofit Act itself does not" -- it says, "Health care" --

MR. FINK: Cite your number.

THE COURT: I'm sorry. 511.

MR. FINK: 511.

THE COURT: I have to go back to the MCL -- hold on. I want to pass this out to you.

[p. 7]

MR. FINK: 500 is a separate code.

THE COURT: It's 550. Getting back to the Nonprofit Health Care Corporation Act, it's 550.126, Subsection 4, "A health care corporation shall not market or transact as defined in Section 402," and so forth. That's not it, either. Hold on. One more time. Where is my original bench note? Here it is.

MR. FINK: Section 1206, your Honor.

THE COURT: There we go. Okay. Here we go. There's two seetions. I'm sorry, I had it all down. Okay. Start over. 550.1201, do you have that? Do you have that?

MR. FINK: 1201?

THE COURT: 1201, Section 201, Subsection 4. It says, "The health care corporation shall not be subject to the laws of this state with respect to insurance corporations except as provided in this act. A health care corporation shall not be subject to the laws of the state with respect to corporations generally," so we don't have an insurance here. The only thing in this act that talks about acceptance acts is that the commissioner regulates it. That's number one.

Number two is the act itself prohibits a nonprofit health care corporation from engaging in insurance transactions. It says in the act that -- [p. 8] again, my personal notes are gone, somewhere in here that they can't engage -- they can't sell insurance. They can't do those kinds of things.

And third and perhaps the most important is that the purpose of the act was not for insurance. It says, "And acts to provide a corporation of -- a nonprofit health care corporation, to provide their rights and so forth." The defined relationship of a health care provider to nonprofit health care corporations, it was basically to provide health care. It wasn't intended in any sense to be an insurance company. And that's my first question to you. Both sides have just assumed it's insurance, but what the law says is specifically it is not.

MR. FINK: I don't agree with the Court, and let me tell you why.

THE COURT: I don't want you to agree with me -

MR. FINK: If I agreed, I would discharge my duty to the Court. First of all, McCarran-Ferguson doesn't require by its expressed terms there to be an insurance company.

THE COURT: I agree with you.

MR. FINK: Okay. Now, let's step back one step further and look at the comprehensive numbers of codes in Michigan dealing with insurance. There are at least [p. 9] countless -- besides the 1956 insurance code which regulates numerous types of insurers, four or five other acts that are encompassed in the insurance codes of the State of Michigan, including Health Care Code S, the fact that is a statute and in this context says, "You shall not sell insurance under the insurance code of 1956," is no different than many of the other specific acts that are in the books in Michigan relating to insurance.

For instance, a surety company, if it has a surety license, cannot sell life insurance and the statute will specifically state that. So the first point is that is a statutory prohibition from a corporation born under this act from engaging in other activities is not evidence that it is not involved in the business of insurance, which the Supreme Court has defined, among other criteria, as the exchange of risk.

THE COURT: Okay. Let me just ask you for a second -- please hold your thought. It's important.

The Court of Appeals will let us know, won't they? But even assuming that's correct in the one for instance, a liability insurance carrier can't write other kinds of insurance, but they are still defined as insurance, in this statute, in addition to prohibiting them from writing almost every kind of insurance that's known in the book, it also says, "Shall not be subject to [p. 10] the laws with respect to insurance corporations."

MR. FINK: Right, except as may be provided in this code.

THE COURT: Yeah. The only -

MR. FINK: It's a different type of insurance entity. You do not draft specific statutes covering specific types of risk for specific state purposes and then say all the other code provisions on unrelated types of risk transfers shall be poured into this.

THE COURT: Except it doesn't quite say that.

MR. FINK: What it says is that the other provisions do not apply to this corporation and its activities unless this code specifically states.

THE COURT: Right.

MR. FINK: That's what it says. And that is absolutely consistent with the creation of a corporate entity or insurance program because Blue Cross or anybody could form a number of companies besides Blue Cross and use this code, but it is formed under law for a very specific type of insurance.

THE COURT: It doesn't say that. It says --

MR. FINK: It says "health care," Judge. You understand that it doesn't use a mantra. It says the other provisions of the insurance code shall not apply here unless it's specifically incorporated. The [p. 11] legislature put together a scheme for insuring individuals for health care under this Act and it said in that context, you don't look to other insurance company provisions; you look to this Act unless we tell you otherwise. And that is a consistent approach in the legislative composition in Michigan.

THE COURT: But in every other act that I've seen that they talk about insurance, they talk about insurance, they say this is an insurance act.

MR. FINK: What if --

THE COURT: This is to provide the risk, and they talk about all those things here. They say, "It is the purpose and intent of this Act and the policy of the legislature to promote an appropriate distribution of health care services for all residents of the state; to promote the progress of science and

art of health care in the state, and to assure for non-group and group subscribers reasonable access and reasonable costs and quality of health care services," and so on and so forth. There is no -- I looked at all the other insurance issues. There's nothing that talks about that. They all talk about risk and all that. This was a public health act.

MR. FINK: Wait a minute. This is the public health code for nonprofit health care providers. This [p. 12] same type of coverage, in general, is provided by, quote, classic insurance companies under other sections of the code.

Blue Cross, in this instance, under this statute, is the insurer of last resort. This was an insurance program that the legislature put in place to assure all persons access to health insurance. That's the purpose of this act. That's the function of this act. The fact that it did not use the mantra "nonprofit insurance company" is -

THE COURT: It went further. It says this is a charitable and benevolent entity.

MR. FINK: The entity that created it -- Blue Cross is a nonprofit corporation. It may not be a profit corporation.

THE COURT: I understand, but there are a lot of nonprofit corporations. This even went further and said, "A charitable and benevolent institution, and funds and property be exempt from taxation," and so on and so forth.

MR. FINK: Right, because the State of Michigan legislatively created a special purpose insurer to afford the people of the State of Michigan health care coverage in a very controlled circumstance. There is transfer of risk. Without any doubt that is the talisman insurance. [p. 13] Per contract,

there is the transfer of risk for premiums. Were you to go to General Motors and ask whether or not it was paying premiums to Blue Cross for coverage for I00,000 employees, it would look at you with fuzzy eyes and say, "Millions upon millions."

Now, what do they get for it? They entered into a group policy or contract. Certificates are issued to the employees and those employees are entitled to the risk transfer with regard to health care.

Ferguson doesn't say you have to use magic words. McCarran-Ferguson says it must be a state law which relates to regulating the business of insurance, and in fact, in the 6th Circuit, and I'll get to that later, goes, in terms of that standard, beyond the narrow. If it were an -- if magic words made determinations over function, then the legislature, by mediocrity, could change magic words, but it would not in this case change function, and that is the transfer of risk under a very complex regulatory statutory system that regulates relationships with various health care providers, which is used, in turn, to determine rates. And if you look at the rate provisions in this statute -- and I'll get to those in a minute -- they talk about risk factors, experience, all the indicia that any insurer looks at, considers, and then makes a decision in setting [p. 14] the rate for the coverage afforded. This is not a talisman type of analysis; it is, rather, a function analysis.

When McCarran-Ferguson states it's a function analysis, it doesn't say it must be an insurance company. It says it's the business of insurance. You could call insurance anything you wanted to.

THE COURT: I agree with you in terms of --

MR. FINK: And this statute -- there is nothing in the health care statute which is antithetical to the analysis that I'm offering. The fact that it says, "Do not go to the other portions of the insurance code for provisions, which, considering whether or not there is compliance with this act, is absolutely consistent with a legislative process of isolating this type of insurance in this type of legislatively-mandated context. The state has the right to define it the way it desires to put it in place, and I believe that that is what has been done here in 196 pages of carefully-crafted regulation, and I would like, if I may, your Honor, to go through a bit of that.

THE COURT: Please.

MR. FINK: So that you have a little more context. I'm flustered. You took me totally out of my sequence.

[p. 15]

THE COURT: Maybe I'll soon be on a computer. I'm learning to be on Westlaw. Go on.

MR. FINK: As the Court has already noted, this statute has explicit purposes. One is to promote health care services to all Michigan residents, appropriate social and appropriate insurance-related objectives. It is to assure subscribers, which are insurers, same thing, different name, same meaning, reasonable access to reasonable quality and costing of care services. To effectuate these purposes, the commissioner of insurance has mandated to regulate and supervise nonprofit health care carriers, such as Blue Cross, to secure for those seeking coverage the opportunity to access health care services at a fair and reasonable price. And here the statutory purposes explicitly provide, "To facilitate access

at a fair and reasonable price," and that there be certain limited appeal rights and reviews.

Now, let's discuss the interrelationship of some of these provisions, and I will try to, as I go through this, to focus. They will object to some of the questions that you've asked. Blue Cross's board is statutorily-imposed. I acknowledge to the Court no other board in the State of Michigan is subject to that regulation other than one under this act. The government appoints four members to this board, not more than 25 [p. 16] percent of the providers may be providers on the board. If they have a board of 16, no more than four could be providers, and by that mean of care providers, one of whom must be a registered nurse, one of whom must be from the provider group that had the largest number of insurance claims in 1984.

Now, I'll talk more about providers and how they are regulated and how the relationship is statutorily-imposed between Blue Cross and providers later.

One of the board of directors may be an officer or a director of Blue Cross -- I'm sorry, one of the directors may be an officer or employee of Blue Cross. The remainder of the directors must be from groups of subscribers. In other words, the insurers, they will have half of the representation on this board. Plaintiffs in this case are all providers that, in this particular instance, are licensed physicians who can provide health care services under the act.

There are 23 provider groups in the Blue Cross system. They are professionals of various types, all of which are focused on health care: Chiropractors, nurses, personnel, this sort of thing. None of the providers are other types of service providers that you might think of in the general sense, such as

computer suppliers, general [p. 17] employees, janitorial services, like providers with very specific defined terms under the statute.

The class plans here are also presumably participating providers; that is, under law they have met the standards set by Blue Cross for their class of providers and have signed a contract. Blue Cross reimbursement arrangements with participating providers effectuate the provider class plans under this statute. Provider class plans are done for each one of the 23 types of providers. Welfare providers that participate in the Blue Cross system, those plans -- and I'll get into them -- are very detailed arrangements and are proposed annually -- or somewhat less than annually, no more than annually, and are reviewed and approved by the State of Michigan.

THE COURT: Let me stop you for one second. Is there any other entity -- rather than using the word "insurance company," any other entity in the business, quote, of insurance, that operates in the same way other than those under the Nonprofit Health Care Corporation Act?

MR. FINK: In Michigan?

THE COURT: In Michigan.

MR. FINK: Not to my knowledge. In terms of the degree of regulation, and I am –

[p. 18]

THE COURT: I'm not talking about the degree of the regulation. I'm talking -- up to that point, we're talking about how the board has composed a statute. Is there any other

entity, quote, in the business of insurance that operated on that basis?

MR. FINK: There is another -- there is another nonprofit health care act as to which one large insurer is incorporated under that is separate from this, Delta Dental, which provides your dental insurance, which is incorporated under an earlier and separate nonprofit health care corporation act, so I guess --

THE COURT: But not under this act?

MR. FINK: No. They could have been, but they had been previously incorporated and chose not to put themselves under this regulatory conduct.

THE COURT: Other than Delta that may have a similar situation, is there any other that you're aware of?

MR. FINK: Your Honor, not off the top of my head.

THE COURT: That's fine.

MR. FINK: There may be some smaller ones, but - -

THE COURT: Okay.

MR. FINK: In terms of health care and in terms [p. 19] of dental care, if you look at the total market, this would be a very significant percentage of those markets. And Blue Cross also provides dental care in the context separate from but very similar to that which is the insurance of Delta Dental.

The definition of a provider contract under the code is, quote, "An agreement between a provider and a health care corporation that contains provisions to implement the provider class plan. The plan, which is put together by Blue Cross and approved by the insurance commission, is the basis for the provider contracts."

The code further defines reimbursement arrangements as, "A policy, practice and method by which a health care corporation makes payments to a provider to implement the provider class plan." The participating provider contracts are frankly a creation of statutes. Sections 502, 518 define the limits, mandate the relationship between these Plaintiffs and Blue Cross, including, one, that the Plaintiffs must accept from Blue Cross as participating providers' payment in full for their services. Blue Cross may not even pay a health care provider who is not entered -- may pay directly to the health care provider who has not entered into a provider contract.

THE COURT: Any other entity that is in the [p. 20] business of insurance that has the same provisions that you're aware of other than Delta, maybe?

MR. FINK: There are in other states. There are in other states.

THE COURT: We're talking about in Michigan. There's Aetna. There is Postal Employee Insurance Carrier.

MR. FINK: They probably have something under the federal plan, which is probably Blue Cross.

THE COURT: Do you know of any other, you know, quote, insurance business for a company or –

MR. FINK: I think it's done in a different way, your Honor.

THE COURT: Here it's done statutorily. The state has given this Nonprofit Health Care Corporation Act the ability to do that; not only the ability, but statutorily there is no company if there is no other "insurance business."

MR. FINK: That is regulated to this extent.

THE COURT: That's given the privilege to this extent. Regulated is one thing, the privilege --

MR. FINK: I don't understand your question about the privilege.

THE COURT: It's a privilege. You're saying before they can pay a provider, that provider has to sign [p. 21] an agreement and all that, by statute.

MR. FINK: Right, and the provider either does or doesn't want to.

THE COURT: Exactly.

MR. FINK: Understood. It's not different than if you have a private insurer who says, "Here's is my -- here's the benefit levels that we will pay." They either accept the insurance or don't.

THE COURT: Here it's a little bit different.

MR. FINK: No.

THE COURT: Because the statute provides that they can't do anything about that. The private company can do whatever they want.

MR. FINK: I understand that. But the fact that that -- well, it can't do anything it wants. There are other regulatory restraints, but it could very clearly state that it will pay amount B and C for certain functions and enter into contracts with providers -- care providers and only pay those amounts. All this says, Judge, is that Blue Cross will pay what is under the provider plan and the provider will accept that payment and that is a direct issue with regard to the risk of the insurer.

THE COURT: Could we look at that? But also when they talk about another paragraph at a cost-plus, it [p. 22] could be because they are not an insured, but they were more of a health care provider. They have a scheme. As they talk about in the introduction, the purpose and intent is to promote health care services for all residents, so forth, as opposed to insured. So I'm off base?

MR. FINK: I think so.

THE COURT: Tell me why.

MR. FINK: You're off base because any person in this state can become an insured under the Blue Cross plan.

THE COURT: Right.

MR. FINK: It is more inclusive by far than private insurance. Private insurers may reject persons from coverage. That's why when I said the state legislature here has created an insurer of last resort, a public policy which was looked at and adopted by the State of Michigan to assure

the circumstances under which all its residents -- and the statute talks about residents -- have the ability to get health care insurance under a statutorily-regulated scheme. It doesn't --

THE COURT: They talk about health care services. They never talk about insurance. They never talk about anything. They talk about it's to provide for [p. 23] health care services.

MR. FINK: Let me ask the Court, if I may, the question.

THE COURT: Sure. I'm trying to understand this.

MR. FINK: What is the difference? Let's assume that I'm not Blue Cross. Today I'm Aetna and I say -- and you're the insurer and I say maybe you have an employer, maybe you have a direct contract, but -- it's a direct contract. Here's the benefits package. We will pay $42.62 for whatever the function is. You go out and have the function done. That's what we'll pay, $42.62.

Now I'm Blue Cross and I say under our regulatory context, we will pay $42.10, whatever, and you have a certificate and you go out and do it, get whatever the service is, and we pay that. Is there a difference between health care service and insurance in that context?

THE COURT: Blue Cross is some few cents less than the others?

MR. FINK: Make it the same.

THE COURT: Their purpose is to provide health care services; it isn't to generate income. It isn't to do any of

those other kinds of things because they are, according to the legislative intent, a benevolent, [p. 24] charitable, non-profitable company, so therefore, they have the ability to go out there. If that person, the uninsured person, the people that can't get insurance and so forth, it seeks to provide for those persons, really, the coverage, to provide health services to those persons. I'm just reading the intent of the law.

MR. FINK: The law is to provide health care accessibility to the residents of this state. I have Blue Cross.

THE COURT: I have Blue Cross, too.

MR. FINK: And I'm not indigent.

THE COURT: And that may be Castleman?

MR. FINK: I doubt that. I understand, and it is regulated by the federal government.

THE COURT: I'm just being sarcastic. The purpose is different, at least as I'm reading the statute.

MR. FINK: The purpose of the State of Michigan is not inconsistent or antithetical to this being insurance. I mean, they have -- they have specified a social objective and they have created a statutory insurer. You can call it a health care corporation, but I'm telling you, if you look at this, the risk changes.

Let me give you another example. I'm insured by Blue Cross. I go in, I had lapro surgery on my right [p. 25] wrist a number of years ago. When I went to the insurer -- I mean, to the doctor, I signed a little note and that little note says I've been advised that my doctor is not a participating physician,

okay? Well, when I went in for a $60 office visit -- I signed that a year later. When I went back for surgery, since this fellow was the surgeon I wanted, I didn't even question it. He wasn't a participating physician. Blue Cross reimbursed me at its participating physician plan level $900 for his surgery. His bill was $3800. Blue Cross sent it to me. I paid the 38. Now, that's insurance.

Under certain circumstances, the insurer pays me X, and if I wanted to go to a participating physician, that participating physician would have accepted the $900. There is an exchange of risk under both of those circumstances, the same as if you have an insurance policy and there are private insurers. They have panels that you go to, a panel physician. If you don't go to a panel physician, they will pay a certain amount and that's it, and if your physician is more, that's your obligation. That's still insurance.

The business of insurance is transferring risk for a consideration. That happens every time a certificate is issued. That transfer of risk and that business of insurance is designed, in this context, to [p. 26] also meet a social objective determined by the legislature. It's still the business of insurance.

THE COURT: You probably have Blue Cross versus commissions back in '89 when the Court of Appeals said it wasn't insurance.

MR. FINK: Which Court of Appeals?

THE COURT: Pardon? Michigan Court of Appeals, 179 Michigan 246, they said Blue Cross/Blue Shield of Michigan is not an insurance company, but it is a health care provider, analyzed it in relation --

MR. FINK: Do you have a case?

THE COURT: I don't have it.

MR. FINK: I'm sure we do. I can't drag it up.

THE COURT: It's way before his time.

MR. FINK: That's true.

THE COURT: Anyhow –

MR. FINK: 179? What were the names?

THE COURT: Blue Cross versus Michigan.

MR. FINK: I don't have that case right at hand, your Honor.

THE COURT: We'll get back there. You can take a look at it and you may have to --

MR. FINK: But in context. I have to look at the context.

THE COURT: I do, too. As I said, I'm on the [p. 27] computer at home at night. I can get to Westlaw and look at it. I'll give you a couple cases.

MR. FINK: Certain risk context, these issues will vary.

THE COURT: I'll give you a couple other sentences and do a quick supplement. Let's move on to what you really want to tell me and we'll supplement this.

MR. FINK: Well, what I really want you to -- what I want to get across to you, besides the fact that we're obviously --

THE COURT: You may be --

MR. FINK: The provider agreements and reimbursement agreements are strictly regulated by statutes in Michigan; an unusual context, true, but nonetheless, not one at all inconsistent with the business of insurance. In fact, it goes further. The statute says that Blue Cross reimbursement arrangements with providers are subject to express regulatory laws, which include insuring subscribers reasonable access, cost and quality of these services.

THE COURT: Any other insurance businesses that have that same requirement that you're aware of other than Delta?

MR. FINK: Not in terms of the next step.

[p. 28]

THE COURT: Okay.

MR. FINK: For instance, there are many provisions in the insurance code that require fair and reasonable premiums and fair and reasonable other context. There are many other areas where the regulators have to look, when they were determining whether or not rates are going to be permitted, as to whether or not there is adequate competition.

THE COURT: That's different than this.

MR. FINK: No, I don't think so. It is a regulatory overview that directly affects the transfer of risk because you

cannot set your premiums. And if you cannot be exempt from coverage, that is a regulation of the transfer of risk, which is, in kind, not different than that which is in this code.

THE COURT: Let's move on. What else do you have?

MR. FINK: In point of fact, Blue Cross has regulated to assure a rate of change in total corporate payments per member, which is, insurers to each provider class is not higher than the compound rate of inflation and real economic growth in the State of Michigan. In other words, rate reimbursements are all driven -- all driven by the regulatory oversight of the insurance commissioner applying statutory formulas, Judge, and I [p. 29] would go through about eight or ten more of these connections, but I sense you would like me to move on.

THE COURT: I would like that. I understand what you're saying, and the truth of the matter is, I probably have to analyze it and since -- I understand what you're saying. I probably have to go through each one and will do so, so why don't you move on to the next item. And I suspect you will include Judge Marino's (ph) opinion in your argument.

MR. FINK: Am I going to?

THE COURT: I suspect you hopefully will. What do you think it's –

MR. FINK: It's not the same regulatory conflict.

THE COURT: Do it in your own time.

MR. FINK: No, that's fine.

THE COURT: I was so anxious to talk about that first issue. Go on, do whatever you want.

MR. FINK: Your Honor, as we set out in the brief, the Nonprofit Act also provides certain appeal processes for providers who don't agree with the provider plans within the context of a code, and those are, in our opinion, exclusive.

The case law in Michigan is really pretty straightforward in that regard. There is no private [p. 30] claim to contest provider plans by providers in the State of Michigan. Case law in the State of Michigan is absolutely without exception on that regard that affects this type of case. That is part of the regulatory-based context of this statute, and the relationship between the provider to carry it and the insurer, they are, unlike the case before Judge Rayner (ph), interrelated and connected by express statute.

The rates that Blue Cross charges are fully approved, reviewed, beaten up on, long proceedings, sometimes for a couple, three years to increase rates in proceedings before the Insurance Commission, and among many of the other factors, the provided plan goals and meeting those goals are fully part and parcel of the setting of the rates for this insurance. Specifically, the statute requires consideration of an additional rate benefit cost. Anticipated benefit costs are driven, in material and substantial part, by the provider plan goals and zero sum statute for provisions.

In addition, this legislative package states after overriding attempts to promote uniformity of rates among all subscribers to the greatest extent practicable, it regulates all contracts -- all insurance or health care service contracts, if you wish to use that language. All the provisions have to be approved by the insurance [p. 31] commission. All the rates for which the

benefits are charged have to be approved by the Insurance Commission. All the relationships with 23 provider groups are part of a plan approved by the Insurance Commission.

THE COURT: Does the insurance commissioner have to approve it for other companies?

MR. FINK: Approves part of that.

THE COURT: But again, not that total package?

MR. FINK: Exactly right, but the degree of regulation is governed by the sovereign --

THE COURT: Absolutely. It differentiates it from insurance.

MR. FINK: No, it doesn't. No, it doesn't.

THE COURT: Than those who are engaged in the insurance business –

MR. FINK: Let me ask you this: State of Michigan had a company called the Accident Fund --

THE COURT: I'm very familiar with that case. I know Blue Cross bought it and some entity -- I don't think they bought it on this entity, but under an entity.

MR. FINK: Well, it created -- there was statutory --

THE COURT: They were set up by the state, run by the state, for the state and so forth.

MR. FINK: No, really, it wasn't, your Honor. [p. 32] It was created by the state. It was part of a series of state actions throughout the United States before the turn of the century when they could not get traditional insurance companies to go into the business and provide workers' compensation at a reasonable -- at least legislative point of view -- cost. Oklahoma, Ohio, a number of them had it. This was an entity that was created. Did it sell insurance?

THE COURT: You're asking me? I haven't studied it.

MR. FINK: Of course it didn't. The fact that it was wholly regulated and all its rates and everything were set by the State of Michigan to the insurer didn't matter. The insurer got a policy; he or she or it got benefits, paid a premium.

THE COURT: I haven't read the act, but I would suspect where in the act it says that the purpose is not to promote health in the state, whatever it is.

MR. FINK: Isn't it inconsistent for a legislature to undertake an objective of promoting health for its citizens by formulating a special purpose type of insurance?

THE COURT: I don't mean to suggest it ought to give it an absolute right. I think they should have it. It is part of a governmental function. That's not an [p. 33] issue here. The issue here is whether or not I have jurisdiction.

MR. FINK: Absolutely. Exactly.

THE COURT: There is an exclusion for me having jurisdiction, and the Ferguson Act, I have to make a determination on whether or not what we're talking about

here is insurance business and I don't know if I necessarily agree with you. The mere fact that it says or does not say insurance is not a factor. What is the key factor is whether or not, you know, it's in the insurance business, and that's my question.

MR. FINK: Actually, there are three parts. Move beyond just the insurance business. My view -- and let me shift to that very briefly, if we can find the context.

THE COURT: Couple minutes. We have to go. Give me what you have.

MR. FINK: Fabe (ph) was a case that Defendant, with the priority of claims on the liquidation of an insurer -- and by the way, if we failed, we would be liquidated the same way as other insurers. But beyond that, your Honor, Fabe looked at the situation and determined in the context of the federal tax statute as to the priority between tax claims, policy claims and administrative expenses, and found as follows. [p. 34]

When looking at the McCarran-Ferguson Act, Fabe held that the broad categories of laws enacted, quote, for the purpose of regulating the business of insurance, close quote, consist of laws. It doesn't say insurance that possesses, "The intention or aim of adjusting, managing or controlling the business of insurance." This category necessarily encompasses more than just the business of insurance. This statutory scheme wherein there is no doubt that there is repeated transfer of risk, there are positions -- there are insurers in the word of Fabe, a statutory program which possesses, "The intention of aim of just additional managing or controlling the business of insurance." It may not be typical. It is, however, the function of the business of

insurance. And under Fabe, that is not as limited a term as it had been perhaps previously.

Provider agreements are so intricately related to the certificates and the insurance issues here that it would be impossible for Blue Cross to fulfill contractual obligations without such agreements because the statute mandates the content, nature of the relationship between the insurer, Blue Cross, and the providers of health care under this statute. That is why their intricate statutory scheme is subject to McCarran-Ferguson's reverse preemptive, briefly touched upon in RICO.

[p. 35]

THE COURT: You say RICO. You mean substantively as may apply to -- you don't have to touch on it. I have to get over the first hurdle, whether or not I even have jurisdiction, but you can touch on it if you think --

MR. FINK: No, it's 4:20. I have no problem. Can I have a few minutes to respond?

THE COURT: Absolutely. The reason I'm telling you that is that I've been pretty focused on the jurisdiction issue and the RICO issue is a whole other issue and it's an issue that I'm going to have to take a hard look at. Even if I got over jurisdiction, I think it may be even harder than jurisdiction in terms of --

MR. FINK: We believe the investigations of jurisdiction of RICO allegations can't be true. I would be willing to give further comments if the Court is going to look -- if the Court were to determine it has jurisdiction.

THE COURT: I will give you an opportunity. We'll be talking about RICO. If I determine I have jurisdiction, we have a lot of discussion. I'm looking not only at you, but at the Plaintiffs as an issue. I'm trying to get over the jurisdiction.

MR. HORTON: Judge, just for an issue, you just want to talk about this, leave the RICO -

[p. 36]

THE COURT: Leave that for another day.

MR. HORTON: I have some displays. I'll save those.

THE COURT: I haven't gotten past the jurisdiction issue and I need some insight on your part.

MR. HORTON: Absolutely. A couple things. First I'd like to mention that Dr. Sanborn, Dr. Genord (ph), other physicians that we brought, as well as some of their colleagues that took this afternoon off and are present in this room, and I wanted to acknowledge it because they believe this is an extremely important case, not only for them, but their colleagues on whom they brought this case.

THE COURT: I love when clients come to court. Then they can see what we do in court and see what the lawyers do, what they get billed for and what they are billed for, and sometimes they get billed for waiting around. I'd like to address some of the initial questions that you asked, Counsel.

MR. HORTON: First, on the issue as to -- you know, quite frankly, Judge, this is a good issue that neither of us

have raised, so obviously both Mr. Fink and myself are doing it on the fly.

THE COURT: I'm not going to spend a lot of time and money, but give you both time simultaneous on that [p. 37] issue. I would like to address a couple things and give you both a couple cases. I haven't had a lot of time on the computer at home.

MR. HORTON: First of all, I think this Nonprofit Health Care Corporation Act in Michigan is known as Blue Cross/Blue Shield of Michigan Act. There has only been one corporation act in it since it was initiated, which I believe is in 1950. I certainly don't pretend to be an expert on the history, but there's certainly nobody else incorporated under that act, at least at any time that I looked at it. I'm unaware of any corporation that's been enacted under it.

The second thing, Judge, and I use my authority for this proposition. Dr. Suez (ph) -- and this relates to the Michigan legislature. He meant what he said and he said what he meant: The legislature is certain 100 percent, at least what I understand, is that when the legislature speaks and speaks unambiguously, it is not our right or do we have the authority to second-guess what a legislature's intent was. The legislature in this case, at least the Michigan legislature that -- at least in this case, it says it's not an insurance company and it has repeated it, "it's not an insurance company." It is not in our -- it is not in our realm to say the legislature is mistaken and that it really is an [p. 38] insurance company or otherwise in the business of insurance.

And I would challenge and take issue with the definition that was provided to you that the exchange of risk is what defines an insurance company or an insurance contract, and

I can give you a couple examples that I thought of that Counsel mentioned, something about General Motors. I bought a car recently and I bought an extended warranty from General Motors. General Motors said I have to pay them a fixed amount of money. If certain things go wrong with my car during a certain period of time, they will fix it at no charge to me. That is not an insurance policy, even though it involves the transfer of risk.

A couple others that occur to me. I may meet with clients to be retained by a client and I may agree to perform a certain task for that client for a fixed fee, and I may have misjudged it. It may take me an awful lot longer than I anticipated, or it may occur much quicker than I had anticipated, but nonetheless, there is a transfer of risk with an unknown outcome and that is not an insurance policy that I entered into at the request of my client.

The other item that I think is important --

THE COURT: He's arguing it's more the insurance [p. 39] business, and I think he's right. He's saying that there's more to it than just risk; there's a regulatory aspect of it and so forth. I think that's what he's saying.

MR. HORTON: I think that's what he's saying, too.

THE COURT: Go on.

MR. HORTON: But I think that the elements of what -- the creator that created Blue Cross and Blue Shield is the most important statement of what is Blue Cross/Blue Shield of Michigan, and that's the Michigan legislature. Moreover, the issue, Judge, that I think Counsel repeatedly talked about, the contact with a place -- and I realize this goes more to RICO's

allegation that we made in the complaint and that we can save for another day, but our claim is not one under RICO, under a breach of contract or breach of a provider plan or somehow the provider plan is unfair or something of that nature. It is simply that of a defrauded vendor to a company, a nonprofit health care corporation, and I can give you another example in that regard.

Presuming that Blue Cross and Blue Shield of Michigan has a number of lawyers throughout the State of Michigan, God forbid they won't pay their lawyers, but nonetheless, those lawyers are nothing more than vendors [p. 40] to Blue Cross and Blue Shield of Michigan. Let's assume for a minute that you conclude it is in the business of insurance, the issue that the cases go to from the Supreme Court on down. They attempted to define it in general terms to courts throughout the country that have applied it in very specific situations such as these; have said that, first and foremost, you look at who the relationship is between, whether it's between the insurance company and an insurer or a patient, or whether it's someone on the other side, a creditor side of things. And I think that's what is interesting about Fabe, and the Supreme Court basically says -- it doesn't basically say; it does say it. It says it right after the punch word "reload." It says basically if you have to enforce the insurance contract, then that's on a risk-sharing side of a relationship and that comes within the McCarran-Ferguson Act.

THE COURT: Why do you think Ferguson cashed out on the insurance policy?

MR. HORTON: I can only tell you basically what the Supreme Court said in some of these cases in the late '30s or thereabouts. It looks like it validated various insurance schemes as being in violation of the antitrust laws. In

response to that, Congress enacted the McCarran-Ferguson Act to exempt it from the antitrust [p. 41] laws and to allow the insurance -- or I'm sorry, to allow state legislatures to regulate the relationship between the company and the insurers.

I think one of the things, Judge, when you're -- you say you're a user of Westlaw and Lexis and you like to do some of this research. You might want to plug into that computer base, lawsuits brought for or against Blue Cross and Blue Shield of Michigan. You'll see a lot of them. They are all over; Blue Cross suing providers, Blue Cross suing insurers, providers suing Blue Cross. Nobody says that that has anything to do with the business of insurance. It has to do with vendors to an insurance company, if you conclude that Blue Cross is an insurance company.

I'll give you an example, Judge. Let's take Allstate -- or let's take AAA or State Farm Insurance Company, whatever you may have your car insured with, and you get in an accident, obviously not your fault, and you have your car at a repair shop. Your car is shipped back to you and there is a dispute between your insurance company and the car repair facility. I've never seen a case and I don't think Defendant contends that the dispute related to that relationship has anything to do with the business of insurance. It has something to do with the business of an insurance company. There is a [p. 42] contractual dispute or a fraud claim or overbilling or some charges between Allstate and Joe's Repair Shop.

Another example is that let's say you have a fire insurance company. You can have a fire in your house and you have to have your house repaired. When the construction company comes in and does the repairs in your kitchen, wherever your

fire might be, and you're taken care of as the insured, but a dispute develops between your fire insurance company and the construction company that repairs your kitchen, no one -- and I've been unable to find any cases and I don't think the Defendant can find any cases that says -- that qualifies under McCarran-Ferguson of the business of insurance. That is simply in dispute between an insurance company and a construction company, nothing more.

And that is exactly what the situation is in this case, Judge. Blue Cross and Blue Shield of Michigan is to provide for people -- to provide health care to their insurers. They do that. This dispute involves a dispute -- this lawsuit involves a dispute between the vendors to Blue Cross and Blue Shield, nothing more. It does -- it has nothing to do with the provision of an exchange of risk. It doesn't have anything to do with what would otherwise be defined as business of insurance. It is simply nothing more than a dispute regarding a [p. 43] company that happens to be in the business of insurance, unrelated to the transfer of risk between the parties in this case.

I think -- I can't recall the name of the case off the top of my head. It's in our brief. There are a number of cases that say, first you don't look at the entire regulatory scheme or framework. What you need to do is look at the specific schedule or a section that is alleged to have regulated the behavior at issue and to see whether the claimant; in this case, RICO, impairs that provision of it. And what you see is there is no section out of the Nonprofit Health Care Corporation Act that we allege is at issue here or that they allege is somehow impaired because this is nothing more than defrauding vendors.

And Judge, this would be some of the information that I would show you. We've pled it in the complaint. Here's basically what if -- you know, obviously you have to fill out claim forms.

THE COURT: I understand what the problem is.

MR. HORTON: Well, repeatedly they provide us with representation that these codes, if they are used to pay promptly, reliance on those codes and reliance on those representations, repeated representations, by the way, that in fact did not occur, and in fact when [p. 44] inquiries were made, specific inquiries, specific representations in writing were made. "Well, we're having a processing problem. Now we think it's fixed, so go ahead and submit the claim and you'll be credited ~~appropriately~~."

I have two more things and we can address these at a later date. Where the claims are made and paid after 9, 11, 12, 13, 15, 16 months after they gave representations to us that these claims would be paid promptly. Judge, this is simply nothing more than a dispute between a vendor. It has nothing to do with sharing of risk. These physicians have been defrauded, is our claim, and I would be happy to provide the evidence and even happier to move forward with discovery.

THE COURT: I've got to get over the jurisdiction. Anything else you have on jurisdiction?

MR. HORTON: I would like the opportunity to address the insurance issue that Mr. Fink --

THE COURT: I'll give each of you an opportunity to do so.

MR. HORTON: Thank you.

MR. FINK: Briefly I'll deal with some of the issues raised by my opposition here. An interesting example of the transfer of a risk was a warranty issued by -- supposedly issued by General Motors. A warranty is [p. 45] not the transfer of risk. It is a promise upon the sale by a manufacturer to correct certain deficiencies. It is the retention of risk, not the transfer. Some states have the insurance commissioner regulate it, but many, many instances the analysis is there is no transfer of risk. It is similar in nature to the type of analysis that defines business. Blue Cross, in consideration of a premium, accepts the risk that the insured transfers to it with regard to certain covered advances. That is the insurance fraud.

Now, I had mentioned that this is a zero sum circumstance under the regulatory scheme. In other words, the amount paid by Blue Cross to providers under provider plans cannot raise more than the rate of inflation under the regulatory scheme, so the impact of various types of lawsuits, especially those such as RICO, with its incredible advantages, directly impact this insurance and this insurance context.

THE COURT: Counsel, your statement, "Directly impacts it by RICO," every industry -

MR. FINK: But every industry is not protected from federal laws if they are an insurance business. That's the point of RICO, in and of itself.

THE COURT: I think Counsel is right. I'm not going to get into the legislature history. Ferguson was [p. 46] designed because of antitrust. RICO wasn't in existence when Ferguson came.

MR. FINK: But that's not the point. The point is that the Congress of the United States states, "No law shall be" --

THE COURT: I agree with you there, but --

MR. FINK: And RICO, in and of itself, the cases say that if that statute interferes, impacts a state regulatory scheme with respect to insurance, it is barred under McCarran-Ferguson. There are a series of cases that compare the types of remedies under state statute in the insurance context. And that's what the issue is in part here, is whether this statute, RICO, with its incredible advantages, is reversed preemptive under McCarran-Ferguson because of its impact in terms of the nature of its remedies and its impact upon the regulatory scheme that the state has chosen and which was recovered to it under McCarran-Ferguson.

THE COURT: Okay.

MR. FINK: A note was made by Counsel about Fabe. The Supreme Court of the United States looked at administrative expenses as the first priority under the Ohio statute concerning a policyholder which came before any other claim, just as another service provider, your Honor. But the Supreme Court stated that that was also [p. 47] within McCarran-Ferguson because it was part and parcel of the statutory regulatory oversight and it was needed within the context of Ohio statute.

THE COURT: It also talks about the relationship between the insurance company and the policyholder and preference absolutely goes to the policyholder who gets the money.

MR. FINK: Before that, his analogy is that I'm a lawyer; therefore, why don't I get paid?

THE COURT: I didn't hear that analogy.

MR. FINK: But what I'm saying is administrative expenses are not policies. They are not payment of policies.

THE COURT: No. It says the relationship between an insurance company and its policyholders, and in that case, if I'm not mistaken, it was the preference -- whether the federal government was first or fifth.

MR. FINK: No, it was first. Ohio was first with administrative expenses. That was lawyers' expenses, the commissioner's expenses, whatever.

THE COURT: The federal government's position is that they were first?

MR. FINK: Right. Two policyholders, three credits, that was their priority. The federal government took the position under tax statutes that they had a [p. 48] priority over everything.

THE COURT: Right.

MR. FINK: The Supreme Court -- remember the defining language, that language used in Fabe? It wasn't related to the business of insurance and it couldn't have been if it was going to become attorney fees and other expenses. It analyzed this in a very broad context in terms of what the impact of a statute was and the breadth of the business of insurance.

THE COURT: Okay.

MR. FINK: Another minute. My partner is coughing behind me because she wants me to ask the Court about the scheduling motion we would like.

THE COURT: Two motions we talked about today, and one is the schedule, and we'll talk about that right now. I want you both to give me a supplemental brief. If you want to simultaneously -- we have a scheduling motion and we have the issue that was just filed in terms of the retaining of the tapes.

MR. FINK: My partner -- the magnetic tape one has not been tied up.

THE COURT : I just got it. I want to talk about it.

MR. FINK: My partner, Kathleen Lang --

THE COURT: We're not going to do it today. [p. 49] It's not up today. I want to discuss it. It's an important motion.

MR. FINK: She would be the important one to discuss it.

THE COURT: Let's do it this way. Number one is, is a week enough time to give you whatever you want to supplement? I'll give you two cases. Number one is Blue Cross of Michigan versus the Governor, 422 Mich 1, 1985 case, and also that's a Michigan Supreme Court case, and Blue Cross versus the Commissioner, 179 Mich Appellate 24-6. That's a 1989 case. Take a look at those cases.

MR. FINK: Can we have two weeks?

THE COURT: You can have two weeks.

MR. HORTON: Two weeks is fine.

THE COURT: All I want you to do is supplement the issues of insurance, both of you.

MR. FINK: Understood.

THE COURT: That's going to determine whether or not I have jurisdiction. The other thing is -- as to the other two things, both sides -- I think the scheduling order is very important. Before you start spending a lot of time and money, let me decide the jurisdiction issue first. But in the interim, hold onto those tapes for two weeks and then we can talk about it.

[p. 50]

MR. HORTON: Can I ask what that is?

THE COURT: I've got a motion to amend on the same day. It's a Defendant Blue Cross Michigan motion for protective order. Basically what they are saying in here, the participants thought basically that in order to retain all of the records that need to be retained, because they are all kept electronically, that it's going to cost about a million dollars for Blue Cross to do it and about a million if they give it to a third party to do it also. So there is a lot of money involved and they want me to make a ruling. I'm not prepared to do so at this point, but I might say, when I read it, a million dollars is a lot of money for anybody. Whether I rule in their favor or your favor, it's a million. It's going to be a million dollars for one side or the other, which leads me -- and I wasn't going to discuss this today, but maybe somewhere down the line there should be discussions about resolving this

matter. I'm not suggesting that there is or isn't. If there is a problem, maybe it should be resolved.

Essentially we're talking about a potential litigation, and very costly. It's litigation that's very obviously important to the Plaintiffs or they wouldn't have taken the time and argued it, and it's important to the Defendant. I'm suggesting that maybe there may be [p. 51] some way of doing it and I would be more than happy to not participate. I have too many rulings, but certainly to focus in on that direction. But we can talk about that at the appropriate time. If you want to talk about that before my ruling, I would be more than happy to.

You know, I always believe if you can resolve a matter -- that's what we're all here to do is resolve matters. If there is a problem, it should be resolved. Whether it can or can't be, I don't know. Maybe with a third-party mediator, if you can't resolve it at this point -

MR. HORTON: It's probably less than you think.

THE COURT: Maybe, but maybe a good mediator that is neutral, maybe it would put you guys together and save money and time and energy and resolve the problem. As I say, I'm not at that point because I still don't know if I have jurisdiction. If I have jurisdiction, I can assure you I will order it, but other than that, okay, two weeks.

MR. FINK: April 6th, I believe, is two weeks.

THE COURT: April 6th, simultaneous filings in my office and limited to ten pages. Is that okay?

MR. HORTON: Sure.

THE COURT: Do it in ten pages.

MR. HORTON: It is my general practice.

[p. 52]

THE COURT: Mine, too. I was going to say, it's an important issue and if you could, the fewer the better. No more than ten. State everything. I don't want either side spending time or money. Don't destroy those tapes or anything. Should discovery come up, they are not destroyed, and then what I will do, as soon as I issue a ruling on this, if I determine I have jurisdiction, I will, at the same time, very short order, do the scheduling conference and also your motion, and if I determine I don't have jurisdiction, I won't.

MR. HORTON: Could I ask that you incorporate some of those things into an order so there is no confusion?

THE COURT: Absolutely. We'll do a complete order.

MR. FINK: Thank you, your Honor.

APPENDIX F

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 04-0107

[Filed December 6, 2004]

IN RE BLUE CROSS & BLUE SHIELD OF MICHIGAN, *Petitioner.*	))))

ORDER

BEFORE: NORRIS and COOK, Circuit Judges; BECKWITH, District Judge.[1]

This class action under the Racketeer Influenced and Corrupt Organizations Act was brought by Michigan physicians who claim that the defendant, Blue Cross and Blue Shield of Michigan ("BCBSM"), engaged in a pattern of failing to pay for medical services they and other physicians had provided to BCBSM subscribers. BCBSM moved to dismiss the action pursuant to the McCarran-Ferguson Act, 15

[1] The Honorable Sandra S. Beckwith, Chief United States District Judge for the Southern District of Ohio, sitting by designation.

U.S.C. § 1012. The district court denied the motion and certified the order for an interlocutory appeal. BCBSM seeks permission to appeal. The plaintiffs oppose the petition.[2]

The district court in its discretion may certify an order for interlocutory appeal if (1) the order involves a controlling question of law, (2) a substantial ground for a difference of opinion exists regarding the correctness of the district court's decision, and (3) an immediate appeal may materially advance the ultimate termination of the litigation. 28 U.S.C. Section 1292(b). *See also In re City of Memphis,* 293 F.3d 345,350 (6th Cir. 2002), *citing Cardwell v. Chesapeake & Ohio Ry. Co,* 504 F.2d 444, 446 (6th Cir. 1974). Review under Section 1292(b) should be sparingly granted and then only in exceptional cases. *Kraus v. Board of County Road Com'rs for Kent County,* 364 F.2d 919, 922 (6th Cir. 1966). A legal question is controlling if resolution of the issue on appeal could materially affect the outcome of the case. *In re Baker & Getty Fin. Services, Inc.,* 954 F.2d 1169, 1 172 n. 8 (6th Cir. 1992). Upon review and consideration, we believe there are substantial grounds for a difference of opinion, and an interlocutory appeal is appropriate.

Therefore, the petition for permission to appeal is GRANTED. An appeal on behalf of the petitioner shall be docketed in this court.

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[2] The Blue Cross and Blue Shield Association has filed an amicus brief in support of BCBSM's petition for permission to appeal. Further BCBSM has tendered a reply to the plaintiffs' response in opposition with a motion for leave to file. We have considered both pleadings.

ENTERED BY ORDER OF THE COURT
/s/ Clerk

APPENDIX G

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 03-CV-72950-DT

[Filed September 7, 2004]

MICHAEL A. GENORD, M.D., ET AL., *Plaintiffs*,	)
v.	)
BLUE CROSS & BLUE SHIELD OF MICHIGAN, *Defendant*.	)

ORDER GRANTING DEFENDANT'S MOTION FOR CERTIFICATION OF ISSUE FOR INTERLOCUTORY APPEAL

On September 1, 2004, this matter came before the court on defendant's motion for certification of an issue for interlocutory appeal. A hearing was held and oral argument heard. For the reasons stated on the record,

IT IS ORDERED that defendant's motion for certification of an issue for interlocutory appeal is granted, the court being of the opinion that the issue in question "is a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order [of July 29, 2004] may materially advance the ultimate termination of the litigation." 28 U.S.C. § 1292(b).

IT IS FURTHER ORDERED that the following issue is so certified: whether plaintiffs' RICO claim is barred by the McCarran-Ferguson Act, 15 U.S.C. § 1012.

IT IS FURTHER ORDERED that defendant's motion to stay the proceedings pending appeal is denied.

/s/ Bernard A. Friedman
Bernard A. Friedman
Chief United States District Judge

Dated: September 7, 2004
Detroit, Michigan

APPENDIX H

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 03-72950

[Filed September 1, 2004]

MICHAEL A. GENORD, M.D.;)
JOHN R. SANBORN, M.D.;)
PAULA A. FISHBAUGH, M.D.;)
ANDREA L. SCHILLER, M.D.;)
MARK D. DYKOWSKI, M.D.;)
JOHN E. ECKELE, M.D.;)
BETTY S. CHU, M.D., on behalf of)
themselves and all others similarly)
situated,)
Plaintiffs,)
)
v.)
)
BLUE CROSS & BLUE SHIELD OF)
MICHIGAN, a Michigan non-profit)
healthcare corporation,)
Defendant.)
)

TRANSCRIPT OF PROCEEDING MOTION FOR CERTIFICATION FOR INTERLOCUTORY APPEAL; MOTION TO STAY PENDING APPEAL

BEFORE: The honorable Bernard A. Friedman, United States District Judge

[p. 3]

THE CLERK: Calling case number 03-72950, Genord versus Blue Cross and Blue Shield of Michigan.

THE COURT: Good afternoon.

MR. WALSH: Good afternoon, your Honor. Sean Walsh, on behalf of the plaintiffs.

MR. FINK: Good afternoon. Joseph Fink, on behalf of defendant Blue Cross and Kathleen Lang on behalf of Blue Cross.

THE COURT: Okay. Today is the date and time for a Motion for Certification for an Interlocutory Appeal as well as a Motion for Stay Pending Appeal.

Let's talk about the Interlocutory Appeal first. I think that makes sense.

MR. FINK: Thank you, your Honor.

On July 29 of this year, this Court opined that Michigan's Non-profit Health Care Act was quote, not enacted for the purposes of regulating business of insurance and that provider

contracts, physician contracts in this context, are not part of business of insurance.

On behalf of Blue Cross, we've filed a Motion to Certify the issue under 12 USC 1292(b)and for a stay on August 9, 2004. [p. 4]

This is a proceeding which has fairly little guidance within the Sixth Circuit, but the guidance that is provided, I believe, militates that the Interlocutory Appeal be granted.

THE COURT: I don't think militates, but I think this is a good case for interlocutory appeal because it goes to the jurisdiction of the Court --

MR. FINK: It does.

THE COURT: It's a single-issue kind of case. But I'll hear what the plaintiffs have to say.

MR. FINK: Okay. And then may I respond if there's any --

THE COURT: Absolutely.

MR. FINK: Thank you, very much.

THE COURT: I've already kind of told you where I was leaning. Maybe you can talk me out of it.

As I say, this is -- this isn't the traditional kind of case where -- but I think it's an important issue. Number one, it's an issue that -- it goes to the jurisdiction of the Court, the heart of it, whether I have jurisdiction or not. So I think it's a good issue for appeal.

MR. WALSH: I agree, Judge. I agree that it's an important issue. I agree it's controlling. And frankly I don't have a lot to say in terms of whether or not it would [p. 5] short-circuit or shortcut the litigation.

Where I part company here is, on the issue of whether's substantial grounds for difference of opinion. And as I read all the parties' briefs and the Court's opinion, this is not necessarily new ground in terms of the actual discrete holding. The statute that creates Blue Cross says what it says. There are a number of cases, you know, starting in the '80s and going back that held the same way. They were simply cases that came to the Court in a different context. The complaint or the novelty here really is the application of this law to these facts. And that's in my understanding not what an interlocutory appeal was intended for. It's a disagreement over what the law is. And there's no disagreement. This not new ground. There's a Florida court that has held very similarly in terms of the activities, whether or not they constitute a business of insurance. There are courts all over the land that have held that it does not.

The fact that on these facts the law falls in plaintiffs' favor is not a substantial ground for difference of opinion, it's what is the law, and a disagreement among the circuits or within the circuit that says we think it's this, no, we think it's that. Here, nobody is saying that. All they're saying is that under these facts we don't think that this constitutes the [p. 6] business of insurance. And I think an interlocutory appeal was intended for a different purpose.

THE COURT: Okay. As I say, I don't -- you know, Wright & Miller would probably agree with you very frankly. I just think it's an important issue that -- if the Court of Appeals is inclined to here it. They may very well say, hey --

in my experience and I haven't certified that many interlocutory appeals, my experience so far they have not ever heard a case that I've certified so your odds are pretty good. I haven't done that many, but every one that I've done that I can remember, they have not taken so -- my impression of the Sixth Circuit is they tend as most circuits do, to disfavor interlocutory appeals.

As I say it goes to the very jurisdiction of this Court, I think it's an important case for them to at least consider.

I disagree with you in terms, I don't think there's that much law. The judge in Florida, I've forgot his name, and I agree as to one part -- one aspect of it. The other aspect of it is I don't think -- I think the Michigan statute is clear. I think my opinion -- I agree with my opinion, but thank God for the Court of Appeals, I could be wrong. So I'm going to certify the question.

The question of stay though is another issue. It's an important issue. I, of course, will hear some [p. 7] argument, but let me just give you my preliminary thought on it.

This is a case, as you know, I think at the time we argued it at Wayne I told you I'd have an opinion to you right away, and it took me a lot longer because I got into a lot more than I thought than I ever would be getting into this particular issue. So I know this case very, very well, and what the allegations are.

Usually, I would say along with the jurisdictional stay, it probably makes sense to have the discovery stayed, and -- because if I don't have jurisdiction then why do the discovery. I'm just giving you my preliminary thought. This is not a ruling so each of you can be prepared to argue where I see the

issue. And where I see the issue on a stay is it's an important issue both for the defendant as well as the plaintiff. For the plaintiff it's more of an economic issue. For the defense, it's a very important institutional issue. But no matter what happens in the Court of Appeals either now as an interlocutory stage or later, at a later stage, the discovery that would be used here, if it's determined that the Court does not have jurisdiction, then the plaintiffs are still going to litigate. They're still going to litigate in state court under a different theory. They've said that, and I'm sure they believe it, and they're doing [p. 8] it in good faith. So any discovery that would take place here certainly wouldn't be wasted discovery because you have to give the parties an opportunity to be prepared and to save a whole lot of time somewhere down the line.

Should the Court of Appeals not grant the interlocutory appeal, then, of course, we're here to stay for the duration. Should they uphold me, of course, we're here for the duration, too.

So, what I'm saying is, I really don't see a downside to discovery. Usually -- not usually, I'm always one of those who are very concerned about litigation costs, and I don't want anybody to ever incur costs when perhaps there's no reason to do so, but in this case the way I see it, this case is not going to go away even if I don't have jurisdiction. It just won't be a RICO case, it will be under other theories.

So with that said, I guess I probably should hear from the defense first.

MR. FINK: It's my understanding that your Honor's analytical fulcrum of this in terms of a stay is that there's a substantial potential that discovery conducted here in this

forum might be utilized in a state forum if there were no jurisdiction. And, therefore, there is not a loss or a wasted expenditure of Blue Cross's or the plaintiffs' fisc. [p. 9]

I would wager that the forum change may well change the exact nature of the discovery that would be pursued even in the class context, even in the limited context, but there would be no RICO. Under state rationales, it is very, very difficult to certify a class on frauds, now, albeit --

THE COURT: Well, we're not a class yet. My discovery would not be based on a class discovery because there's no class.

MR. FINK: Okay.

Then what we're talking about here though from the Court's point of view would be thus merit discovery.

The decisional basis and we have another motion here for bifurcation, is limit only to class at this juncture because that is the context of this suit. And in that context if there is no jurisdiction and if this case thus must be re-filed within a separate jurisdictional body, I would suggest that there may well be a material waste of treasure because even class discovery issues are of some economic movements especially when you're the defendant because there will be certain issues that will be related to historic bodies of data within our client's data bases, file cabinets, et cetera.

And I think there's one other facet the Court could keep in mind if it were inclined, and that is that [p. 10] these types of certified appeals are included in the cases which the Sixth Circuit issues a routine briefing schedule with an expedited argument, and direct submission on brief. I think that when

all things are considered, that this delay, if there is one, is one of some small moment in the context of a piece of litigation of this size and one which would militate and I -- I'll withdraw that word.

THE COURT: No, that's fine.

MR. FINK: Would suggest that to conserve resources, if discovery costs a half million to a million dollars, in digging out data and that sort of thing even for class purposes and could well, and there's a jurisdictional decision that says it should go to state court, that information may or may not be pertinent but it would be focused on class at this juncture.

THE COURT: Okay.

MR. FINK: Thanks.

THE COURT: Thank you.

MR. WALSH: I'll start from the back. In terms of a distinction between class and merit discovery, I did speak to counsel before the hearing. Although Michigan doesn't have that distinction, in theory I don't have any objection to that. I think there's some value in deciding up front whether there's going to a class or not before you launch headlong. Where we part company is the need for [p. 11] eighteen months to do that. We have seven plaintiffs. They can talk to them for seven days, or conduct them for fourteen days. I mean, I think a reasonable period is sixty days or something in that neighborhood to get whatever it is that needs to be gotten in terms of class discovery. But more importantly --

THE COURT: So you Would have no problems -- at least an initial concept to do the class discovery, and what you're saying is you don't need that much time.

MR. WALSH: It's just not that big of chore.

THE COURT: How much time do you need?

MR. WALSH: I think it would be about fifty days, frankly.

But beyond that, I mean, this is an '03 case. We're now into the summer of '04, and we don't have a single shred of merit discovery having been given to us. So the idea of staying discovery while this appeal winds its way to the Sixth Circuit is a little bit distasteful. I understand that these move a little bit more quickly than would a standard appeal. But the fact of the matter is part of this case is a time value of money issue, and we are now years, and years, and years out and frankly I think that Blue Cross has spent what it would have spent on discovery in fighting it so far.

You know, we have sent out eight discovery [p. 12] requests that we have no answers to, and we've asked for one deposition. We're not looking to conduct a war of attrition. We want to get to the point. I mean, this is a plaintiff's case. And frankly from an economic standpoint it doesn't benefit us to, you know, to spend money for the sake of spending money. But there are a lot of things having to do with these claims that would be applicable either in this forum or in the state court, and frankly, I think we ought to be able to get at them.

THE COURT: Okay. I think in this matter discovery is appropriate since both sides really have no fundamental -- the

defense doesn't want discovery, I understand it, but if there is, it wants it limited to class. Since both sides have no fundamental problem with at least limiting it to discovery, and it is an important case for both sides. I understand that it is very economic for the plaintiffs, and very precedent setting for the defense, but it's an important case for both sides.

How much time do you believe for the class?

MR. FINK: Your Honor, we would want at least six months for class discovery because it's going to be a two-way. They're going to be asking for materials also.

We have not -- and I think it's appropriate to know, we have moved within every time limit imposed by the Court and have met all time limits. The only request was [p. 13] that I just had finished trying a case and went on vacation and asked for another five or six days for this hearing. So we have not sought to delay. We have filed appropriate motions for protective orders. We will move with -- in accordance with the Court rules.

THE COURT: I'll split it, a hundred and twenty days for class discovery, and in a hundred and twenty days we will also what's going on in the Court of Appeals.

MR. FINK: I would hope.

THE COURT: A hundred and twenty days. Again, I don't speak for the Court of Appeals, and I have no idea how swift they are, not swift, in terms of deciding cases. I would imagine in a hundred and twenty days we'll know whether they're even accepting this case. And if they do accept it, I think we'll know whether they've accept it on an expedited

basis, and we may be able to get some indication what an expedited basis means by that point.

So -- then I'll a schedule a conference, an informal conference where we can sit down; see where we are at that point; see what the Court of Appeals has done or not done; see what's going on in discovery, and then reevaluate where we are; what we're going to do and be in a position to either start additional discovery, or be in a position to say, hey, the Court of Appeals has expedited it, you know, maybe we should all wait and see if they've [p. 14] told us that it's a three-month or four-month period.

But I think we all would be in a better position to know. If they don't take the interlocutory appeal, then we'll on that date set a trial, very frankly.

MR. FINK: I appreciate it, your Honor. I would presume that hearing -- or that informal conference, we would then set briefing schedules and --

THE COURT: Exactly.

MR. FINKS: Define the nature of the hearing.

THE COURT: On that one, depending where we stand, if we have jurisdiction, or they're not taking it, or whatever it happens to be, I'll give you a trial date on that date. If we've heard from the Court of Appeals and they're taking it, we should have some idea of their calendar and we can talk about those kinds of issues.

MR. FINK: Thank you, very much, your Honor.

THE COURT: The conference will take place on Monday, January 10th, at 2:00 p.m.

Is that a good time?

How about this: When you get back to your office, why don't you take a look. We'll do the order -- draft it today, we'll enter it tomorrow, if that's not a good date, give us a couple dates that's good -- you know, right around that time. When you get back your office, call each other. I mean, I'm here that whole week. So [p. 15] give me a couple of dates if that's not a good date for both of you, and I will pick one of those dates.

MR. FINK: Thank you.

THE COURT: Okay. Thank you.

I'm sorry, was there something else?

MR. WALSH: Well, there were a number of motions but I think your decision –

THE COURT: I think this covers all of them.

MR. FINK: I think it does, your Honor.

THE COURT: There's nothing I can do on the others.

MR. WALSH: Fair enough.

MR. FINK: Thank you, your Honor.

THE COURT: If you have any problems, let me know. If it's something I can do by telephone phone, without filing

a lot of papers -- if I'm here, I'm always willing to do a hearing real quick on the telephone.

MR. WALSH: Fair enough.

MR. FINK: Thank you, your Honor.

(Proceedings concluded.)

APPENDIX I

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 04-2486

[Filed June 26, 2006]

MICHAEL A. GENORD, M.D.;	)
JOHN R. SANBORN, M.D.;	)
PAULA A. FISHBAUGH, M.D.;	)
ANDREA L. SCHILLER, M.D.;	)
MARK D. DYKOWSKI, M.D.;	)
JOHN E. ECKELE, M.D.;	)
BETTY S. CHU, M.D.,	)
Plaintiffs-Appellees,	)
	)
v.	)
	)
BLUE CROSS & BLUE SHIELD OF MICHIGAN,	)
Defendant-Appellant.	)
	)

MANDATE

Pursuant to the court's disposition that was filed 3/14/06 the mandate for this case hereby issues today.

A True Copy.

COSTS: None

Attest: /s/ Deputy Clerk

APPENDIX J

UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

No. 04-2486

[Filed June 26, 2006]

MICHAEL A. GENORD, M.D.;	)
JOHN R. SANBORN, M.D.;	)
PAULA A. FISHBAUGH, M.D.;	)
ANDREA L. SCHILLER, M.D.;	)
MARK D. DYKOWSKI, M.D.;	)
JOHN E. ECKELE, M.D.;	)
BETTY S. CHU, M.D.,	)
Plaintiffs-Appellees,	)
	)
v.	)
	)
BLUE CROSS & BLUE SHIELD OF MICHIGAN,	)
Defendant-Appellant.	)
	)

ORDER

BEFORE: RYAN, CLAY, and GILMAN, Circuit Judges.

The appellant has submitted a motion to stay the issuance of the mandate pending application for a writ of certiorari. The appellees have responded in opposition.

Upon consideration, it is **ORDERED** that the motion be, and it hereby is, **DENIED**.

ENTERED BY ORDER OF THIS COURT

/s/ Leonard Green
Leonard Green, Clerk

APPENDIX K

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 03-72950

[Filed January 20, 2005]

MICHAEL A. GENORD, M.D.;	)
JOHN R. SANBORN, M.D.;	)
PAULA A. FISHBAUGH, M.D.;	)
ANDREA L. SCHILLER, M.D.;	)
MARK D. DYKOWSKI, M.D.;	)
JOHN E. ECKELE, M.D.;	)
BETTY S. CHU, M.D., on behalf of	)
themselves and all others similarly	)
situated,	)
Plaintiffs,	)
	)
v.	)
	)
BLUE CROSS & BLUE SHIELD OF	)
MICHIGAN, a Michigan non-profit	)
healthcare corporation,	)
Defendant.	)
	)

STIPULATION FOR ENTRY OF ORDER GRANTING STAY OF PROCEEDING

NOW COME the parties, Plaintiffs and Blue Cross Blue Shield of Michigan ("BCBSM"), by and through their representative counsel and pursuant to LR 7.1(a)(1), and hereby stipulate and agree to the entry of an order providing as follows:

1. On December 9, 2004, BCBSM filed its "Motion for Stay of Proceedings Pending Appeal" (the "Motion") and an accompanying Brief in Support of same.

2. BCBSM's Motion requests, pursuant to 20 U.S.C. Section 1292(b) and F.R.A.P. 8, that the Court issue an Order staying the captioned proceeding pending the resolution of the interlocutory appeal now pending before the Sixth Circuit Court of Appeals (Sixth Circuit Case No. 04-2486).

3. BCBSM previously filed a "Motion for Clarification of Issue for Interlocutory Appeal to the Sixth Circuit Court of Appeals under 28 U.S.C. § 1292(b) and Motion for Stay Pending Appeal," which Motion was heard by the Court on September 1, 2004. At the September 1, 2004 hearing, at which the Court granted BCBSM's request for certification of the interlocutory appeal, the Court suggested that it would be appropriate to review the issue of a stay of further trial court proceedings in the event the Sixth Circuit granted BCBSM's Petition for Permission to Appeal – which has since occurred.

4. Plaintiffs concur in the relief requested by BCBSM's Motion.

5. Accordingly, the Parties request that the Court enter an Order staying the captioned proceeding in all regards

pending the resolution of the referenced interlocutory appeal now before the Sixth Circuit.

By: /s/ Jonathan S. Groat
Joseph A. Fink
Kathleen A. Lang
Jonathan S. Groat
Attorneys for Defendants

Dated: January 18, 2005

By: /s/ Linda M. Watson
William H. Horton
Linda M. Watson
Attorneys for Plaintiffs

Dated: January 18, 2005

IT IS SO ORDERED:

/s/ Bernard A. Friedman
Honorable Bernard A. Friedman
United States District Court Judge

Dated: January 20, 2005

APPENDIX L

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

No. 03-72950

[Filed December 10, 2003]

MICHAEL A. GENORD, M.D.; et al.	)
Plaintiffs,	)
	)
v.	)
	)
BLUE CROSS & BLUE SHIELD OF MICHIGAN, a Michigan non-profit healthcare corporation,	)
Defendant.	)

FIRST AMENDED CLASS ACTION COMPLAINT AND JURY DEMAND

NOW COME Plaintiffs, by their attorneys, COX, HODGMAN & GIARMARCO, P.C., and complain of Defendant as follows:

1. The Plaintiffs are physicians and bring this action on behalf of themselves and a class of similarly situated Michigan physicians providing gynecology services.

Plaintiffs and class members provide medical services to Defendant's insureds on a fee-for-service basis.

2. Defendant is a Michigan non-profit healthcare corporation located in Detroit. It is the parent corporation of a number of subsidiaries that provide healthcare services to tens of thousands of enrollees in various healthcare plans statewide. Defendant, its subsidiaries and healthcare plans are collectively referred to as Defendant.

3. This Court has subject matter jurisdiction pursuant to 28 USC §§ 1331 and 1367 because Count I arises under the laws of the United States and the other counts are subject to this Court's supplementary jurisdiction.

4. Plaintiffs and Defendant have entered into a contract where, among other things, Defendant has agreed to process claims submitted by Plaintiffs on behalf of Defendant's insureds in a timely manner. In addition, Michigan law requires insurers such as Defendant to pay claims in 45 days.

5. Following the provision of medical services, Plaintiffs and class members are required to submit a coded claim form, the purpose of which is to provide a uniform language that accurately describes the medical, surgical or diagnostic service a physician has rendered, and to give Defendant the information it needs to process a claim for payment.

6. Each Plaintiff and class member relies on Defendant's agreement, statutory obligation and representations that it will pay them in a timely manner for rendering covered services by not billing the insured, and by requesting payment through the submission of standard claim forms and using standardized coding.

7. During the spring of 2002, Defendant announced it had changed the billing codes for gynecological services. It instructed Plaintiffs and class members to learn and understand the new codes and made them effective retroactive to November, 2001.

8. Plaintiffs began using the new codes as instructed by Defendant. However, Defendant rejected the claims, asserting that the wrong codes were being used. Plaintiffs verified that the claims were being submitted with the codes Defendant had instructed them to use and resubmitted them.

9. Defendant continued to reject the claims. At various times, Defendant asserted that the wrong codes were being used, that Defendant's computer system had not been properly programmed, and other reasons. Defendant has admitted to Plaintiffs and others that it has wrongfully rejected proper claims submitted by Plaintiffs. Defendant has continued to wrongfully reject proper claims.

10. Plaintiffs have been damaged through the loss of the use of the money owed them, the improper payment of a reduced amount on certain claims, the substantially increased costs related to rebilling claims because of the retroactive coding change and the costs related to tracking and resubmitting proper claims which had been improperly rejected, among other things. In addition, on information and belief, some claims were never paid because they were rejected and not resubmitted as a result of confusing rejections, different and contradictory instructions from Defendant, and other reasons.

11. Plaintiffs and others whose practice consists of a substantial amount of gynecological services for patients insured by Defendant have also suffered consequential

damages as a result of Defendant's conduct. The potential for such damages was known and foreseeable to Defendant at the time it entered into contracts with Plaintiffs.

CLASS ALLEGATIONS

12. Plaintiffs bring this action on their own behalf and, pursuant to FRCP 23, as a class action on behalf of a statewide class of persons defined as all physicians performing gynecological medical services who, from November 1, 2002, to the date of certification, provided services to any patient insured by or who was a member or beneficiary of any plan administered by Defendant.

13. The members of the class are so numerous that joinder of all members is impracticable. On information and belief (and certainly within the knowledge of Defendant), there are more than 5,000 physicians performing gynecological medical services in Michigan.

14. The question of law and fact common to the class includes, but is not limited to, whether Defendant has delayed or denied proper claims, improperly paid reduced amounts, or whether Defendant has made the claim process so daunting that some claims are simply abandoned. The prosecution of separate actions by individual members of the class would create the risk of adjudications with respect to individual members of the class which would, as a practical matter, be dispositive of the interests of other members of the class who are not parties to the action, or could substantially impair or impede their ability to protect their interests and of inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible and inconsistent rights within the plaintiff class.

15. The claims of the named class representatives and the absent class members have a common origin and share a common basis. Their claims originate from the same practice and breach by Defendant, and the Defendant acts in the same way toward the Plaintiffs and the members of the class. Consequently, each named Plaintiff and class member has been the victim of Defendant's actions.

16. The proposed class representatives' claims are typical of the claims of absent class members. If brought individually, the claims of each class member would necessarily require proof of the same material and substantive facts, and seek the same remedies.

17. The named Plaintiffs are willing and prepared to serve the Court and proposed class in a representative capacity. The Plaintiffs will fairly and adequately protect the interest of the class and have no interest adverse to, or which directly and irrevocably conflicts with, the interests of other members of the class.

18. The named Plaintiffs have engaged the services of counsel indicated below. Counsel are experienced in class litigation, will adequately prosecute this action, and will otherwise represent the named class representatives and absent class members.

19. A class action is superior to other available methods for the fair and efficient adjudication of the controversies because individual claims by the class members are impractical as the costs of prosecution far exceed what any one Plaintiff or class member has at stake and the proposed class action is manageable.

COUNT I

VIOLATION OF RICO

20. Plaintiffs incorporate the above allegations by reference.

21. In addition to breaching its contractual and statutory duties, Defendant, on its own and as part of a common scheme, systematically denied and delayed payments due to physicians so that they were not paid in a timely manner for the covered services, improperly paid reduced amounts, or made the claims process so daunting that some claims were simply abandoned or otherwise lost. This is done through an enterprise that denies payments to physicians based on processing physicians' bills using automated programs which manipulate standard coding practices to artificially deny and delay payments.

22. Defendant insures such a large pool of patients that they are able to perpetuate this scheme through its economic power and market dominance.

23. Based upon Plaintiffs' current knowledge, the following persons constitute a group of individuals associated in fact that Plaintiffs refer to as the "BCBSM Enterprise": (1) Defendant and its subsidiaries that provide healthcare services to tens of thousands of enrollees in various healthcare plans statewide; (2) other health insurance companies not named as defendants; (3) HBOC McKesson and other third-party entities which develop claims processing systems or components for BCBSM; (4) BCBSM Claims Support and all other third-party entities utilized by Defendant to facilitate claims processing; and (5) Electronic Data Interchange ("EDI"). These entities are associated in fact as part of a

healthcare network with the common purpose of facilitating medical services, through coding procedures and claims processing, and earning profits from providing those services.

24. The BCBSM Enterprise is an ongoing organization engaging in or affecting interstate commerce. The members of the BCBSM Enterprise also have an existence separate and distinct from the enterprise. The BCBSM Enterprise has an ascertainable structure separate and apart from the pattern of racketeering activity in which Defendant engaged.

25. In order to retain monies and interest owed physicians in the manner set forth above, Defendant needs a system that allows it to manipulate and control reimbursements to physicians and conceal the manner in which it is done. The BCBSM Enterprise provides Defendant with that system and ability, and their control of and participation in it is necessary for the successful operation of the scheme. Defendant controls and operates the BCBSM Enterprise and conducts and participates in the Enterprise's affairs as follows:

A. By designing, developing, and implementing new computer systems to process new coding guidelines and claims processing procedures to be used in order to reimburse provider claims;

B. By disseminating and distributing those new coding guidelines and claims processing information through meetings, correspondence, and publications, including The Record, at which attendees and recipients share and receive billing information;

C. By approving, engaging, and requiring coding guidelines, standards and forms to be used by its

subsidiaries, third-party entities, claims support, EDI, and others, instructions, such as through The Record and other correspondence, to systematically and routinely deny clean claims;

D. By dictating the use of those coding guidelines, standards and instructions within the new computer system to systematically and routinely deny and delay payment of clean claims;

E. By directing, engaging and paying HBOC McKesson and other third-party entities to develop the automated systems for editing and manipulating the claims information which systematically and routinely deny clean claims; and

F. By dictating and supporting BCBSM Claims Support, EDI and other third-party entities as a common entry point for physician claim data to assist Defendant in processing claims in a coordinated fashion in which they are systematically and routinely denied.

26. In executing the above-described scheme to systematically and routinely deny and delay payment of clean claims by means of false pretenses, representations or promises, Defendant, in violation of 18 USC § 1341 and 18 USC § 1343, placed in post offices and transmitted by wire, including but not limited to, agreements, manuals, guidelines, instructions, newsletters, correspondence and similar information related to the new coding scheme. In addition, Defendant mailed and transmitted by wire rejections of clean claims it knew or should have known to be false.

27. The false and fraudulent matter and misrepresentations sent by Defendant via the Postal Service or wire and on which Plaintiff relied, include:

A. **The April 2002 Issue Of The Record (Defendant's Physician Publication).** BCBSM notified its providers of changes in coding procedures that had gone into effect on November 27, 2001, for annual gynecological exams, requiring providers to begin using an S code combined with an E&M code, otherwise, providers would not be reimbursed; despite these representations to providers that BCBSM's new system was ready to accept the new codes and therefore pay provider claims, clean claims submitted under these codes were systematically and routinely rejected by BCBSM;

B. **The January 2003 Issue Of The Record.** BCBSM notified providers that it would start accepting the Q code for payment beginning September 2002; however, despite these representations that BCBSM's system would accept this code and pay provider claims, BCBSM's system did not accept this code and clean claims submitted under this code were systematically and routinely rejected by BCBSM;

C. **Correspondence From BCBSM.** Sonia A. Parks, M.D., a BCBSM employee in the Physician's Ombudsman Department, sent a letter to Plaintiff Genord dated February 7, 2003, again representing that if the physicians followed BCBSM billing codes and instructions, they would be timely paid. Relying on these further

representations and requirements to be followed in order to have claims reimbursed, Plaintiffs continued to submit claims accordingly. These clean claims, however, were still systematically and routinely rejected by BCBSM;

D. **Additional Correspondence.** Additional correspondence from BCBSM which concealed or failed to disclose that BCBSM would and did use techniques, procedures, systems and software that deprived or delayed Plaintiffs and class members of payment on clean claims submitted in accordance with BCBSM instructions, representations, and requirements;

E. **A Letter From BCBSM Vice President Of Medical Affairs.** Chief Medical Officer Thomas L. Simmer, M.D. of BCBSM sent a letter to Plaintiff Genord dated March 2003 stating that Defendant has worked diligently in correcting processing problems which were allegedly causing the rejections. However, Defendant failed to rectify the problem represented, and Defendant continued for several months to systematically and routinely reject clean claims submitted and resubmitted by Plaintiffs in accordance with Defendant's continued instructions to follow the new coding procedures; and

F. **Provider Vouchers.** Provider vouchers received by mail and wire from BCBSM and its third-party entities that facilitated the claims process, systematically and routinely contained false rejections of clean claims when BCBSM was well aware after all of the complaints by physicians that

the rejections created systematically and routinely by the computer system were false rejections.

28. Defendant specifically intended to deceive Plaintiffs and the class members when it knowingly transmitted, and continued to transmit, these misrepresentations, acts of concealment and failures to disclose through the mail and wires for the purpose of obtaining or retaining for a period of time their property for Defendant's gain.

29. Defendant either knew or recklessly disregarded the fact that the misrepresentations and omissions described above were material, and Plaintiffs and the class members relied on the misrepresentations and omissions when Plaintiffs and the class members submitted claims pursuant to Defendant's instructions, only to have these clean claims systematically and routinely rejected by Defendant.

30. Defendant knew, particularly after months of correspondence, telephone calls and other forms of complaints by physicians, that its processing system would not properly identify, approve and pay clean claims. Yet, Defendant proceeded to implement and operate the system and continued to require Plaintiffs to submit claims and resubmit rejected claims in accordance with the faulty system's coding guidelines despite its knowledge and the misrepresentations to Plaintiffs that the system problems were being diligently corrected.

31. As a result, Defendant has obtained money and property belonging to the Plaintiffs and class members, and Plaintiffs and the class members have been injured in their business or property by Defendant's overt acts of mail and wire fraud.

32. Defendant has engaged in a pattern of racketeering activity by committing at least two acts of racketeering activity as described above within the past 10 years. Indeed, Defendant has committed thousands of acts of racketeering activity. Each act of racketeering activity was related, had a similar purpose, involved the same or similar participants and method of commission, had similar results and impacted similar victims, including Plaintiffs and class members. These multiple acts were related to each other and amount to and pose a threat of continued racketeering activity. Defendant engaged in more than one such criminal scheme and episode of the foregoing wire and mail fraud and racketeering activity.

33. Defendant received, and continues to receive income from its participation as a principal in an extensive pattern of racketeering activity in violation of Section 1962(a) of RICO. That income is reinvested to finance future racketeering activity, and the future operation of the BCBSM Enterprise.

34. Through the patterns of racketeering activities outlined above, Defendant has also conducted and participated in the affairs of BCBSM Enterprise in violation of Section 1962© of RICO.

35. Defendant's conspiracy to secure money due Plaintiffs and class members for its own use through the fraudulent scheme described above violates Section 1962(d) of RICO.

36. Defendant knowingly and with intent, sought to, and has committed predicate acts, in engaging in a pattern of racketeering activity, and in violating USC § 1962(a) and © as described above.

37. As a direct and proximate result, Plaintiffs and class members have been injured in their business or property by both the predicate acts which make up Defendant's patterns of racketeering and their investments and reinvestment of income to operate, expand and perpetuate the BCBSM Enterprise.

38. Specifically, Plaintiffs and class members have been injured in their business or property by the denial of timely payments for services rendered and properly submitted to Defendant, including but not limited to, the loss of interest on both late and withheld payments.

WHEREFORE, Plaintiffs pray that this Honorable Court do the following:

A. Award them triple damages in an amount determined by the trier of fact and enhanced pursuant to statute;

B. Enjoin Defendant from denying proper claims and require it to pay proper claims in a timely fashion; and

C. Award Plaintiffs their costs, interest and attorney fees and such other relief as is just and proper.

COUNT II

BREACH OF CONTRACT

39. Plaintiffs incorporate the above paragraphs by reference.

40. Defendant has agreed with Plaintiffs and class members that it would process claims submitted by Plaintiffs in a timely fashion and pay proper claims.

41. Defendant has breached its agreement by failing to process and pay proper claims in a timely fashion.

42. Plaintiffs have been damaged as a result of Defendant's breach.

WHEREFORE, Plaintiffs request that this Court do the following:

A. Award them damages in an amount determined by the trier of fact;

B. Enjoin Defendant from denying proper claims and require it to pay proper claims in a timely fashion; and

C. Award Plaintiffs their costs, interest and attorney fees and such other relief as is just and proper.

COUNT III

VIOLATION OF STATUTE

43. Plaintiffs incorporate the above paragraphs by reference.

44. Defendant is required by statute (MCLA 500.2006) to pay clean claims within 45 days.

45. Defendant has breached that obligation.

46. Plaintiffs have been damaged as a result of Defendant's breach, and are entitled to, among other things, an award of 12% interest per annum on unpaid claims, as provided by statute.

WHEREFORE, Plaintiffs request that the trier of fact award them damages and their costs, interest and attorney fees.

COUNT IV

UNJUST ENRICHMENT

47. Plaintiffs incorporate the above paragraphs by reference.

48. Defendant has received the benefit and has been enriched from Plaintiffs' medical services to its insureds.

49. It would be unjust and inequitable for it to retain the benefit of these services, use of Plaintiffs' money and other items without being required to pay for them.

WHEREFORE, Plaintiffs request that the trier of fact award them damages and their costs, interest and attorney fees.

JURY DEMAND

Plaintiffs demand trial by jury.

/s/ William H. Horton
William H. Horton
Linda M. Watson
Attorneys for Plaintiffs

Michael Quaine
Co-Counsel for Plaintiffs

Dated: December 10, 2003

APPENDIX M

RELEVANT STATUTORY PROVISIONS

Mich. Comp. Laws § 550.53:

(1) An organization may enter into a prudent purchaser agreement with 1 or more health care providers of a specific service to control health care costs, assure appropriate utilization of health care services, and maintain quality of health care. The organization may limit the number of prudent purchaser agreements entered into pursuant to this section if the number of agreements is sufficient to assure reasonable levels of access to health care services for recipients of those services. The number of prudent purchaser agreements authorized by this section that are necessary to assure reasonable levels of access to health care services for recipients shall be determined by the organization. However, the organization shall offer a prudent purchaser agreement, comparable to those agreements with other members of the provider panel, to at least 1 health care provider that provides the applicable health care services and is located within a reasonable distance from the recipients of those health care services, if a health care provider that provides the applicable health care services is located within that reasonable distance.

* * *

(3) A prudent purchaser agreement shall be based upon the following written standards which shall be filed by the organization with the commissioner on a form and in a

manner that is uniformly developed and applied by the commissioner before the initial provider panel is formed:

(a) Standards for maintaining quality health care.

(b) Standards for controlling health care costs.

(c) Standards for assuring appropriate utilization of health care services.

(d) Standards for assuring reasonable levels of access to health care services.

(e) Other standards considered appropriate by the organization.

Mich. Comp. Laws § 550.1102(1):

It is the purpose of and intent of this act, and the policy of the legislature, to promote an appropriate distribution of health care services for all residents of this state, to promote the progress of the science and art of health care in this state, and to assure for nongroup and group subscribers, reasonable access to, and reasonable cost and quality of, health care services, in recognition that the health care financing system is an essential part of the general health, safety, and welfare of the people of this state. Each corporation subject to this act is declared to be a charitable and benevolent institution and its funds and property shall be exempt from taxation by this state or any political subdivision of this state.

Mich. Comp. Laws § 550.1401:

(7) A health care corporation shall not directly reimburse a provider in this state who has not entered into a participating contract with the corporation.

Mich. Comp. Laws § 550.1404:

(1) A person who has reason to believe that a health care corporation has violated section 402 or 403, if the violation was with respect to an action or inaction of the corporation with respect to that person, is entitled to a private informal managerial-level conference with the corporation, and to a review before the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 before an independent review organization under the patient's right to independent review act, if the conference fails to resolve the dispute.

(2) A health care corporation shall establish reasonable internal procedures to provide a person with a private informal managerial-level conference as provided in subsection (1). These procedures shall provide all of the following:

(a) That a final determination will be made in writing by the health care corporation not later than 35 calendar days after a grievance is submitted in writing by the member. The timing for the 35-calendar-day period may be tolled, however, for any period of time the member is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 days if the health care corporation has not received requested information from a health provider.

(b) A method of providing the person, upon request and payment of a reasonable copying charge, with information pertinent to the denial of a certificate or to the rate charged.

(c) A method for resolving the dispute promptly and informally, while protecting the interests of both the person and the corporation.

(d) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the member along with written notifications as required under the patient's right to independent review act.

(e) A method for providing summary data on the number and types of complaints and grievances filed. Beginning April 15, 2001, this summary data for the prior calendar year shall be filed annually with the commissioner on forms provided by the commissioner.

(3) If the health care corporation fails to provide a conference and proposed resolution within 30 days after a request by a person, or if the person disagrees with the proposed resolution of the corporation after completion of the conference, the person is entitled to a determination of the matter by the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 by an independent review organization under the patient's right to independent review act.

(4) A health care corporation shall establish, as part of its internal procedures, an expedited grievance procedure. The expedited grievance procedure shall provide that a determination will be made by the health care corporation not later than 72 hours after receipt of the grievance. Within 10

days after receipt of a determination, the member may request a determination of the matter by the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 by an independent review organization under the patient's right to independent review act. If the determination by the health care corporation is made orally, the health care corporation shall provide a written confirmation of the determination to the member not later than 2 business days after the oral determination. An expedited grievance under this subsection applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subsections (1) to (3) would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function. This subsection does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services. As used in this section, "grievance" means an oral or written statement, by a member to the health care corporation that the health care corporation has wrongfully refused or failed to respond in a timely manner to a request for benefits or payment.

(5) The commissioner shall by rule establish a procedure for determination under this section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the person and the health care corporation.

(6) If either the health care corporation or a person other than a member disagrees with a determination of the commissioner or his or her designee under this section, the commissioner or his or her designee, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act.

(7) A member may authorize in writing any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding under this section.

Mich. Comp. Laws § 550.1502:

(1) A health care corporation may enter into participating contracts for reimbursement with professional health care providers practicing legally in this state for health care services or with health practitioners practicing legally in any other jurisdiction for health care services that the professional health care providers or practitioners may legally perform. A participating contract may cover all members or may be a separate and individual contract on a per claim basis, as set forth in the provider class plan, if, in entering into a separate and individual contract on a per claim basis, the participating provider certifies to the health care corporation:

(a) That the provider will accept payment from the corporation as payment in full for services rendered for the specified claim for the member indicated.

* * *

(3) A health care corporation shall not restrict the methods of diagnosis or treatment of professional health care providers who treat members. Except as otherwise provided in section 502a, each member of the health care corporation shall at all times have a choice of professional health care providers. This subsection does not apply to limitations in benefits contained in certificates, to the reimbursement provisions of a provider contract or reimbursement arrangement, or to standards set by the corporation for all contracting providers. A health care corporation may refuse to reimburse a health care provider for health care services that are overutilized,

including those services rendered, ordered, or prescribed to an extent that is greater than reasonably necessary.

Mich. Comp. Laws § 550.1502a:

(1) For the purpose of doing business as an organization under the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63, a health care corporation may enter into prudent purchaser agreements with health care providers pursuant to this section and the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63.

(2) A health care corporation may offer group contracts under which subscribers shall be required, as a condition of coverage, to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(3) An individual who is a member of a group who is offered the option of being a subscriber under a contract pursuant to subsection (2) shall also be offered the option of being a subscriber under a contract pursuant to subsection (4). This subsection applies only if the group in which the individual is a member has 25 or more members or if the provider panel that is providing the services under the contract is limited by the organization to a specific number pursuant to section 3(1) of the prudent purchaser act, 1984 PA 233, MCL 550.53.

(4) A health care corporation may offer group contracts under which subscribers who elect to obtain services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such providers. Contracts offered pursuant to this subsection shall not, as a condition of

coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(5) An individual who is a member of a group who is offered the option of being a subscriber under a contract pursuant to subsection (2) or (4) shall also be offered the option of being a subscriber under a contract that:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(6) Subsection (5) applies only if the group in which the individual is a member has 25 or more members and if the group on December 20, 1984 had health care coverage through the group sponsor.

(7) A health care corporation may offer individual contracts under which subscribers shall be required, as a condition of coverage, to obtain services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom such a contract is offered shall also be offered a contract that:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(8) A health care corporation may offer individual contracts under which subscribers who elect to obtain services from health care providers who have entered into prudent purchaser agreements shall realize a financial advantage or other advantage by selecting such providers. Contracts offered pursuant to this subsection shall not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements. A person to whom such a contract is offered shall also be offered a contract that:

(a) Does not, as a condition of coverage, require subscribers to obtain services exclusively from health care providers who have entered into prudent purchaser agreements.

(b) Does not give a financial advantage or other advantage to a subscriber who elects to obtain services from health care providers who have entered into prudent purchaser agreements.

(9) The rates charged by a corporation for coverage under contracts issued under this section shall not be unreasonably lower than what is necessary to meet the expenses of the corporation for providing this coverage and shall not have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(10) Contracts entered into under this section are not subject to the provisions of sections 504 to 518.

(11) A corporation shall not discriminate against a class of health care providers when entering into prudent purchaser agreements with health care providers for its provider panel. This subsection does not:

(a) Prohibit the formation of a provider panel consisting of a single class of providers when a service provided for in the specifications of a purchaser may be legally provided only by a single class of providers.

(b) Prohibit the formation of a provider panel that conforms to the specifications of a purchaser of the coverage authorized by this section so long as the specifications do not exclude any class of health care providers who may legally perform the services included in the coverage.

(c) Require an organization that has uniformly applied the standards filed pursuant to section 3(3) of the prudent purchaser act, 1984 PA 233, MCL 550.53, to contract with any individual provider.

(12) Nothing in the 1984 amendatory act that added this section applies to any contract that was in existence before December 20, 1984, or the renewal of such contract.

(13) Notwithstanding any other provision of this act, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, a health care corporation is not required to provide benefits or reimburse for a practice of optometric service unless that service was included in the definition of

practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(14) Notwithstanding any other provision of this act, a health care corporation offering coverage under a prudent purchaser agreement is not required to reimburse for services otherwise covered if the services were performed by a member of a health care profession, which health care profession was not licensed or registered by this state on or before January 1, 1998 but that becomes a health care profession licensed or registered by this state after January 1, 1998. This subsection does not change the status of a health care profession that was licensed or registered by this state on or before January 1, 1998.

Mich. Comp. Laws § 550.1504:

(1) A health care corporation shall, with respect to providers, contract with or enter into a reimbursement arrangement to assure subscribers reasonable access to, and reasonable cost and quality of, health care services, in accordance with the following goals:

(a) There will be an appropriate number of providers throughout this state to assure the availability of certificate-covered health care services to each subscriber.

(b) Providers will meet and abide by reasonable standards of health care quality.

(c) Providers will be subject to reimbursement arrangements that will assure a rate of change in the total corporation payment per member to each provider class that is not higher than the compound rate of inflation and real economic growth.

Mich. Admin. Code R. 550.101:

As used in these rules:

(a) "Claim" means a request for payment by a provider under his or her agreement with a health care corporation or a request for benefits or payment by a subscriber or the subscriber's agent or representative under the subscriber's contract, certificate, or rider. A claim does not include applicable copayments or deductibles.

(b) "Commissioner" means the Michigan insurance commissioner or the designees of the insurance commissioner.

(c) "Complaint" means a written statement to a health care corporation requesting further explanation or information regarding a certificate or a denial of a claim or disputing a denial of a claim.

(d) "Days" means, unless otherwise stated, calendar days.

(e) "Grievance" means a written statement by a person to a health care corporation or to the commissioner or his or her designees that a health care corporation has wrongfully refused a claim in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being §550.1402 or §550.1403 of the Michigan Compiled Laws, or has otherwise violated section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, if such refusal or violation is with respect to an action or inaction of the corporation with respect to that person.

(f) "Grievant" means a person who makes a grievance.

(g) "Meeting" means a meeting of the commissioner and either or both of the following to resolve a grievance:

(i) A person who has made a grievance or the person's agent or representative.

(ii) The health care corporation about which the grievance was made.

(h) "Private informal managerial-level conference" means a personal meeting between a grievant and the grievant's agent or representative and a representative of the health care corporation.

(i) "Refusal to pay a claim" means to fail to pay all or any part of a health care benefit claim.

(j) "Working days" means all calendar days, except Saturdays, Sundays, and state of Michigan holidays.

Mich. Admin. Code R. 550.102:

(1) A person who believes that a health care corporation has wrongfully refused his or her claim in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being §550.1402 or §550.1403 of the Michigan Compiled Laws, or has otherwise violated section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, shall be entitled to a private informal managerial-level conference with the health care corporation.

(2) The private informal managerial-level conference shall be held within a reasonably accessible distance from the Michigan residence of the grievant and shall be at a time reasonably convenient to the grievant or the grievant's agent

or representative. At the request of the grievant, the conference may be held by telephone.

(3) A person may make a request to a health care corporation for a private informal managerial-level conference only after the person has submitted a complaint to the health care corporation and either the person has received a response from the health care corporation or the health care corporation has failed to respond to the complaint within 30 days.

(4) At the time of a refusal to pay a claim, the health care corporation shall provide in writing to the member and, if the claim was made by a provider, to the provider, a clear, concise, and specific explanation of all the reasons for the refusal. This notice shall notify the member or provider of the member's or provider's right to request a private informal managerial-level conference if the member or provider believes the refusal to be in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being §550.1402 or §550.1403 of the Michigan Compiled Laws.

(5) The notice of a person's right to a private informal managerial-level conference shall be subject to the prior approval of the commissioner. The notice shall reasonably inform members and providers of their rights under the law and these rules and shall contain language that is understandable to a person of ordinary intelligence. The notice shall contain, at a minimum, an explanation of all of the following:

(a) The person's right to contact the health care corporation by telephone if the person has a question

concerning the health care corporation's refusal to pay a claim.

(b) The person's right to submit a written complaint to the health care corporation. The person shall not be required to contact the health care corporation by telephone before submitting a complaint.

(c) The health care corporation's obligation to respond in writing to the complaint within 30 days after it is received by the health care corporation.

(d) The person's right to request, in writing, a private informal managerial-level conference either in person or by telephone with the health care corporation if the person disagrees with the response to the complaint or if the health care corporation fails to respond to a complaint within 30 days.

(e) The health care corporation's obligation to provide a person a private informal managerial-level conference and a proposed resolution within 30 days of the health care corporation's receipt of the written request for the conference.

(f) The person's right to request and receive, subject to a reasonable copying charge, copies of information relating to the person's grievance. A reasonable copying charge shall not exceed the rate charged for copying by the Michigan insurance bureau in accordance with Act No. 442 of Public Acts of 1976, as amended, being §15.231 et seq. of the Michigan Compiled Laws.

(g) The person's right to receive, upon request, a copy of a subscriber handbook which contains the language of section 402 and section 403 of Act No. 350 of the Public Acts of

1980, as amended, being §§550.1402 and 550.1403 of the Michigan Compiled Laws.

(h) The person's right to appeal to the commissioner if the person disagrees with the resolution proposed by the health care corporation or if the health care corporation fails to provide a private informal managerial-level conference and proposed resolution within 30 days of receipt of the request.

(i) The person's right to appoint another person to act as his or her agent or representative in the complaint process, the private informal managerial-level conference, and the appeal to the commissioner.

(6) A health care corporation shall review and respond in writing to a complaint within 30 days. The complaint shall be reviewed by a person of greater authority than those persons who respond to telephone inquiries to the health care corporation. The response of the health care corporation shall again notify the person who made the complaint of his or her right to a private managerial-level conference if the person believes that a health care corporation has violated section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being §550.1402 or §550.1403 of the Michigan Compiled Laws. The notice shall use language similar to the language approved pursuant to subrule (4) of this rule.

(7) A health care corporation shall provide a subscriber handbook to every subscriber as soon as possible after these rules take effect. The handbook shall contain, at a minimum, a copy of the language of section 402 and section 403 of Act No. 350 of the Public Acts of 1980, as amended, being §§550.1402 and 550.1403 of the Michigan Compiled Laws.

Mich. Admin. Code R. 550.103:

(1) Within 10 days of the conclusion of the private informal managerial-level conference, the health care corporation shall provide all of the following information to the grievant:

(a) The proposed resolution of the health care corporation.

(b) The facts, with supporting documentation, upon which the proposed resolution is based.

(c) The specific section or sections of the law, certificate, contract, or other written policy or document upon which the proposed resolution is based.

(d) A statement explaining the person's right to appeal the matter to the commissioner within 120 days after receipt of the health care corporation's written statement provided in subrule (2) of this rule.

(e) A statement describing the status of the claim involved.

(2) The information provided pursuant to subrule (1) of this rule shall be in writing. Such a written statement shall be phrased in terms which are understandable to a person of ordinary intelligence.

Mich. Admin. Code R. 550.104:

(1) A person who is entitled to a private informal managerial-level conference shall be entitled to a review and determination of his or her grievance by the commissioner in either of the following situations:

(a) The person disagrees with the resolution proposed by the health care corporation after the private informal managerial-level conference.

(b) The health care corporation fails to provide the person with a private informal managerial-level conference and proposed resolution within 30 days of a grievance by that person.

(2) The grievant may appeal to the commissioner within 120 days of the date the person received the health care corporation's proposed resolution or, if no resolution is provided, within 120 days after the end of the 30-day period in which the health care corporation is to provide a proposed resolution. This 120-day time limit may be extended by the commissioner if he or she believes that there is just cause to do so.

(3) The grievant is entitled to a review of the matter by the commissioner either by a review of written materials or, upon a request by either the grievant or the health care corporation, through a meeting with the parties involved in the dispute.

Mich. Admin. Code R. 550.105:

(1) When conducting a review of the dispute through written materials, the commissioner shall, by first-class mail, notify the health care corporation of the matter under consideration and inform the health care corporation of the time period within which any reply shall be made. Such notification shall be given within 10 working days after the commissioner receives the grievance.

(2) When conducting a review of a dispute through a meeting with the parties involved, the commissioner shall do all of the following within 10 working days after he or she receives the grievance:

(a) Set a time for the meeting and notify the grievant, by first-class mail, of the time and place of the meeting; however, the meeting shall not be scheduled within 20 days of the date that the commissioner notifies the grievant and health care corporation of the scheduled date.

(b) Send, by first-class mail, at the same time the grievant is notified, a copy of the notice of the scheduled meeting to the health care corporation.

(c) Inform the health care corporation of the time period within which any answer shall be made.

(3) The commissioner or commissioner's designee shall conduct meetings in a manner which allows the disputing parties to present relevant information to substantiate their positions.

Mich. Admin. Code R. 550.106:

The commissioner or commissioner's designee shall base his or her decision upon written materials submitted by the parties and the statements of the parties at the meeting, if any. Failure of either party to supply any information in a timely manner shall result in a decision based on information available to the commissioner or the commissioner's designee at the time of the decision.

Mich. Admin. Code R. 550.107:

(1) If a meeting pursuant to R 550.105 is not held, the commissioner or the commissioner's designee shall prepare a written decision within 10 working days after the health care corporation submits an answer to a grievance or, if an answer is not submitted, within 10 working days after the time for submitting an answer has expired.

(2) If a meeting is held, the commissioner or the commissioner's designee shall prepare a written decision within 10 working days after the meeting is concluded.

(3) The commissioner or the commissioner's designee shall notify the health care corporation and the grievant of the right to request a contested case hearing if a party disagrees with the written decision. A request for a contested case hearing shall be made within 60 days after the written decision has been mailed. If so requested, the commissioner shall proceed to schedule the matter as a contested case hearing under Act No. 306 of the Public Acts of 1969, as amended, being §24.201 et seq. of the Michigan Compiled Laws.

Mich. Admin. Code R. 550.108:

(1) If the decision by the commissioner or the commissioner's designee indicates that the grievant's claim was wrongfully refused in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being §550.1402 or §550.1403 of the Michigan Compiled Laws, the wrongfully refused claim shall be paid within 30 days of the date the decision is mailed to the health care corporation.

(2) A claim which is payable to a member shall bear simple interest from a date of 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim.